

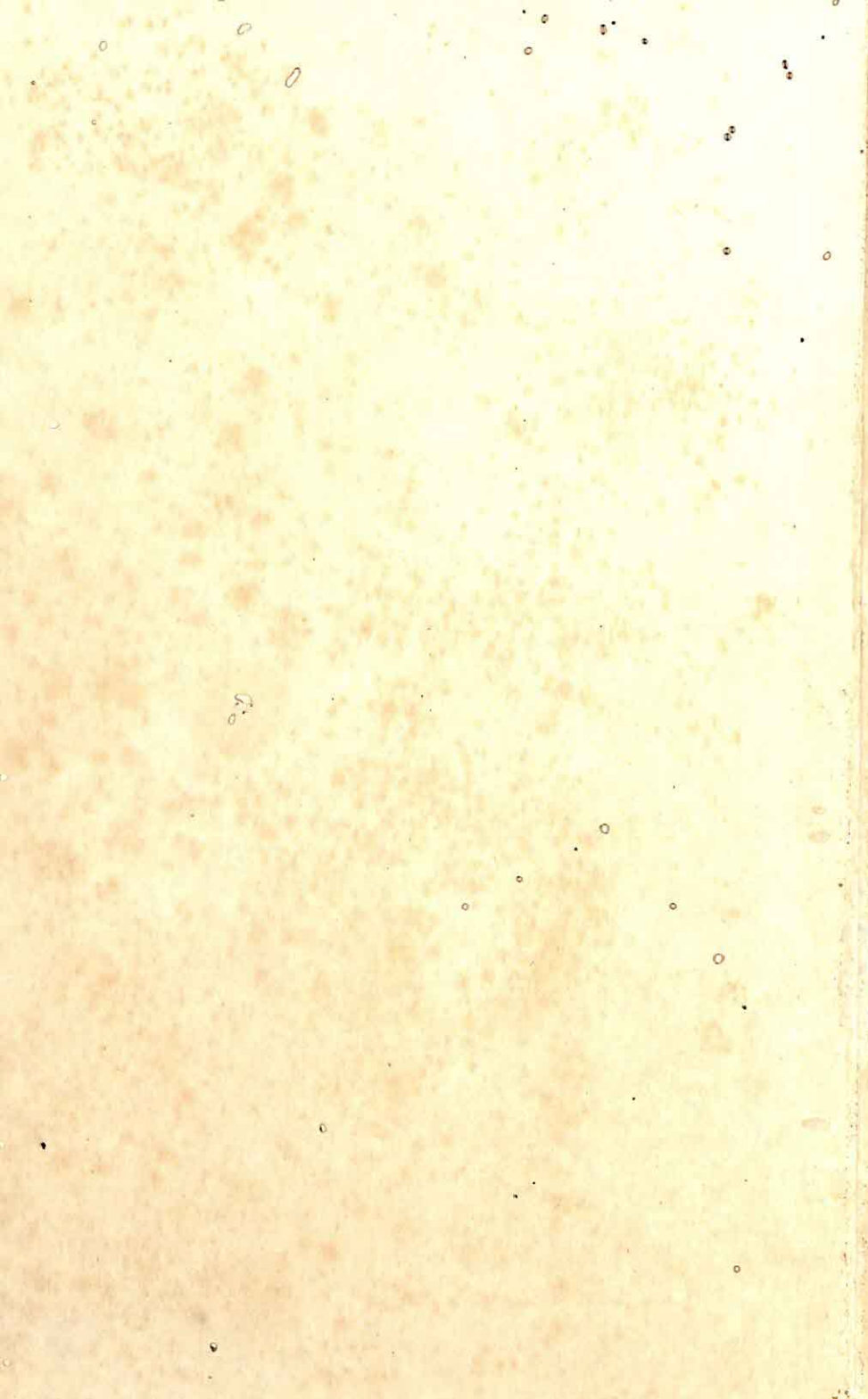


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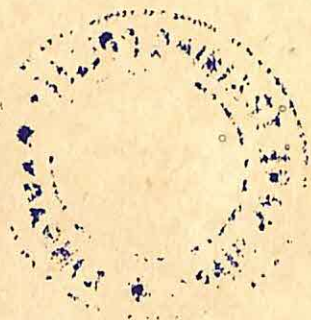
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EMOTIONAL DISORDERS
OF CHILDREN

by O. Spurgeon English and Gerald H. J. Pearson
EMOTIONAL PROBLEMS OF LIVING

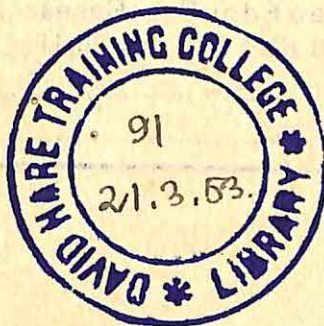


Emotional Disorders of Children

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M.D.

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London

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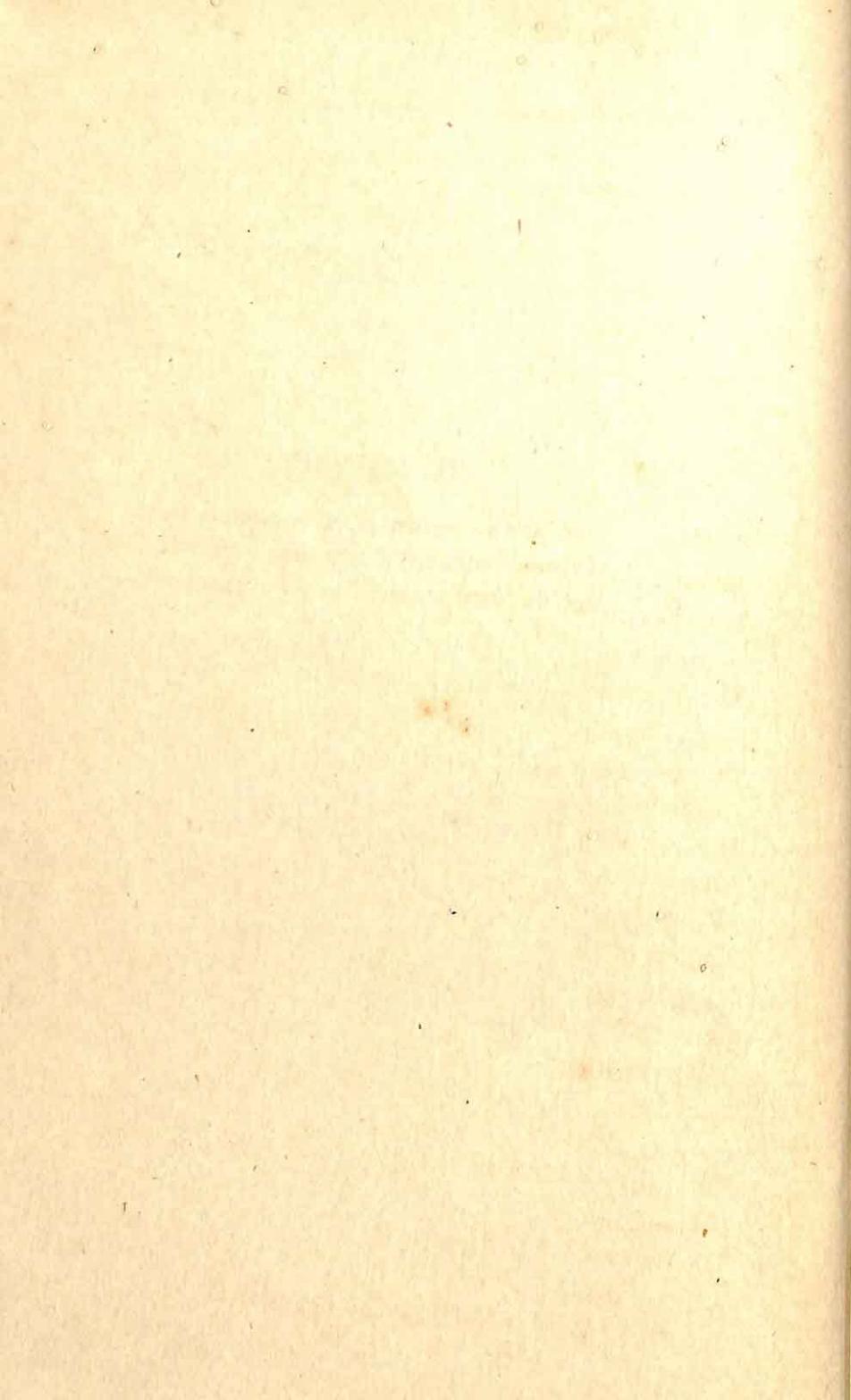
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TO MY WIFE

who was so patient in relinquishing, from
the small amount of free time a physician
has, the time required to write this book.



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PREFACE

TWENTY-FIVE years ago the psychoanalysis of children and of adolescents was a young and emerging specialty. Its progress has been phenomenal during the past quarter of a century, so that now it is a well-recognized subdivision of psychiatry. During this period it has acquired a voluminous literature, which is scattered widely throughout periodicals and texts that often are not well known or available to medical students and physicians who are in general practice or whose specialties are along other than psychiatric lines. The purpose of this book is to bring together in one volume this body of well-authenticated knowledge through a discussion of actual case situations, a method so ably developed years ago by Dr. Richard Cabot. I intend to present the salient facts by which the psychic structure of the clinical problems of children who suffer from neuroses, character disturbances, and psychoses can be better understood, the various categories of such clinical problems, the procedures for their management, and the difficulties inherent in these procedures.

My discussion of the case material is psychoanalytically oriented. I have found that only through psychoanalysis can there be an adequate understanding of the dynamics of the psyche in health or illness, and that without such an understanding there can be no helpful management of the child who is emotionally ill. I realize that I have discussed the dynamics of some cases rather superficially, while in others I have tried to present the deep unconscious motivations of the illness. This tends to make difficulties for the reader. If he lacks a real understanding of depth psychology, he will have difficulty in following the discussion of certain cases. If he has more insight, the discussion of others will appear superficial. I have been unable to find a plan that would make a more uniform presentation. Certain cases can be explained simply. Others are the re-

sult of complicated psychic processes that cannot be understood unless unraveled. I realize also that in preparing a book of this kind there is always a tendency to oversimplify the psychodynamics, which are in reality extremely complicated. I have tried not to select cases that are easy to demonstrate. Instead, I have described the type of case that is seen in the everyday practice of psychiatry. In many instances the case material has purposely been left unorganized because of a desire to present the case as it actually comes to the psychiatrist. He has to learn what material is pertinent and what is not.

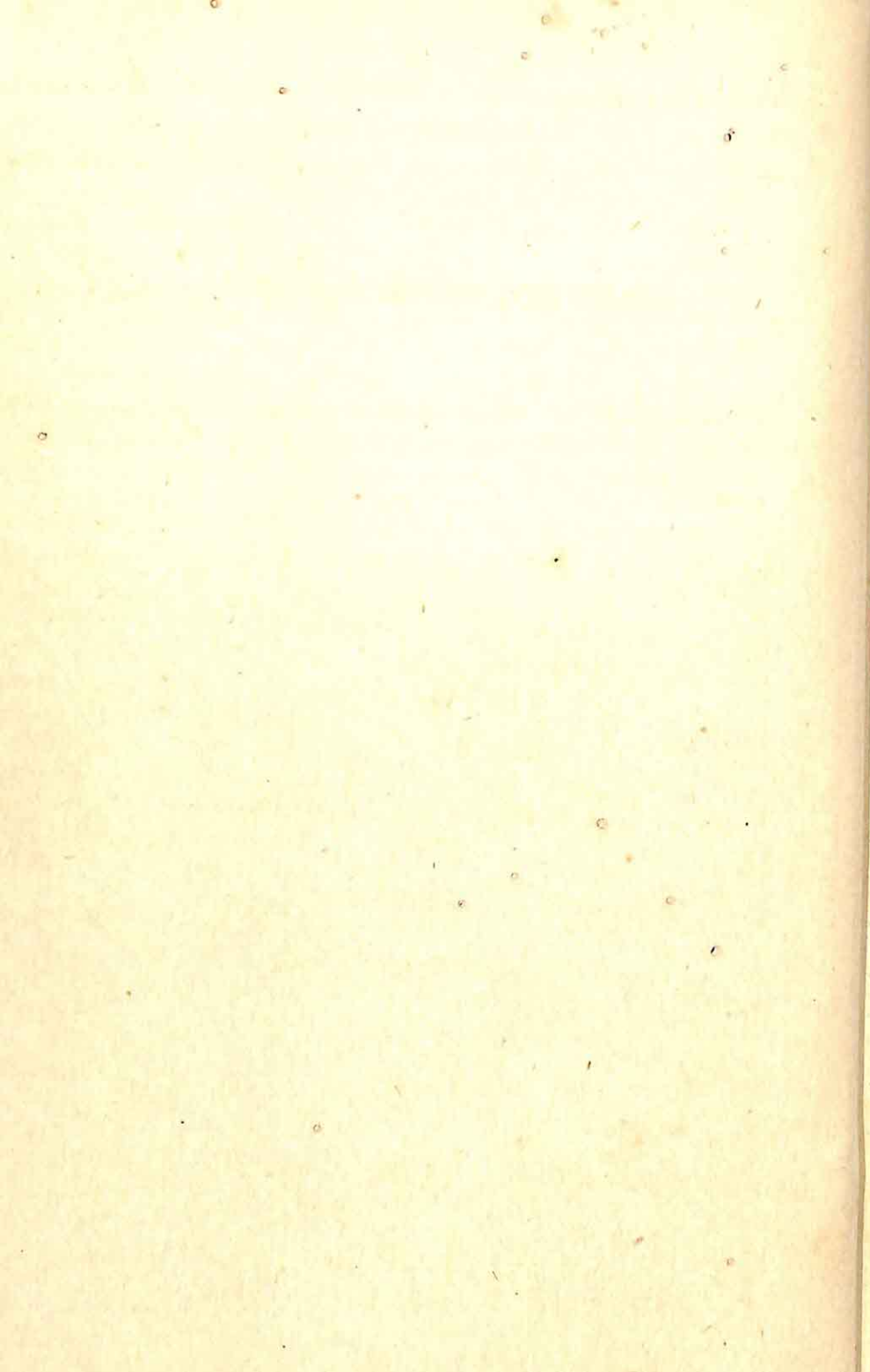
To the reader who is not too well acquainted with the problems of human behavior, particularly those of children, I would recommend that he first study the basic concepts about human behavior and the structure of the neuroses and psychoses, perhaps through the medium of the two books *Emotional Problems of Living* and *Common Neuroses of Children and Adults*, written in collaboration with Dr. O. S. English.

I wish to express my indebtedness to Freud and to his collaborators and successors in psychoanalysis. Many psychoanalysts whose contributions have been most helpful I have not known personally. To a few with whom I have had the personal privilege of working, I wish to express my appreciation and gratitude for their help to me in attaining a better understanding of my own childhood problems and psychodynamics and therefore of the problems and psychodynamics of others.

I wish to express my appreciation and gratitude to the many senior students at Temple University Medical School and to the psychiatrists who have worked with me in the Clinic for Child Psychiatry for their discussions and questions about various cases and for the help I received through these discussions in organizing this material so that it will meet the needs that they demonstrated.

I am grateful to Mrs. Norman G. Schmuhl. The idea for the organization of this book was the fulfillment of a manifest dream wish: several years ago she dreamed that she walked into a large bookstore and in front of her was a huge counter filled with copies of a new book—*A Casebook of Child Psychiatry*—written by me. From this time on, she, with the help of Mrs. Oliver Freud and Mrs. Herbert Myers, proceeded to collect notes on my case conferences, and this book is based on these notes. I am grateful also to my good friend Dr. G. Henry Katz for the suggestions he made after a careful critical reading of the manuscript, to Dr. George Sprague for the critical reading of Chapter IV, and to Mrs. William G. Gordon and to Mrs. Samuel D. Auerbach for their help in its preparation.

EMOTIONAL DISORDERS OF CHILDREN



CHAPTER ONE

INTRODUCTION

WHEN A CHILD complains of a headache, his parents take him to a physician, who carefully examines his body in order to determine the cause for the pain. At the same time the child may be making poor scholastic progress, which fact the parents discuss with the teacher, who has already been studying his responses to her teaching. Perhaps both the parents and the teacher decide that an examination of his intelligence level is desirable and consult a psychologist for a thorough study of his intellectual capacities. Also, the parents may be disturbed by his unbecoming behavior and may consult a minister, who looks carefully into the state of his little parishioner's soul. The parents themselves may be discussing their marital life with a social worker, who is carefully examining the sociological relationships in the family.

Each of these disciplines will be bringing its training and skills to bear on those aspects of the child's life with which it is best equipped to deal. In the highly complex state of human knowledge, it is inevitable that such specialization will exist and continue to exist. It is unfortunate, however, when no one of the various specialists knows or realizes that the others are also contributing to the study. The parents may not mention the child's behavior or lack of school progress to the physician nor the headaches to the minister, and unless one of the specialists departs from his special field of investigation to inquire about the data from the other fields, there will be no worth-while coordination of all the material. The physician may not realize that the child is finding that his home and school life are a headache to him. The educator and psychologist may not realize that he cannot absorb

his studies because he is worried by the quarreling at home. The minister may not realize that the child's behavior is his way of responding to the parents' discord. One or more of the investigators—perhaps all—will deal with a particular aspect of behavior, unaware that this behavior is only part of one individual and cannot be understood alone. This attitude is perhaps more true of the physician than it is of the others.

It is the responsibility of the physician whom the parents have consulted about their child's headaches to study the child as a human being living in a specific environment and not merely as a physical body with a pain in the head. His function is to alleviate all suffering and misery caused by illness. He does this by instituting measures that will prevent healthy persons from becoming diseased, that will cure the sick person, or that will, if his illness is incurable, reduce his suffering and disability to a minimum. In order to carry out this function effectively, he must receive a thorough training in the anatomy, physiology, and pathology of the human being, in the signs and symptoms of the healthy and of the disturbed functioning of the human organism, in the nature and organization of the agents that produce disease, and in the technical procedures best suited to preserve life and restore health. With these platitudinous statements everyone, physician and layman, will agree. But the physician's skill and training must go further. Too frequently his training in the functions of the human personality and in the so-called personality dysfunctions—i.e., disturbances of the integration of the human person—is woefully defective and unscientific. For psychic dysfunctions cause as much suffering and discomfort as do those of the bodily organs and often express themselves by actual disorders of organs. Unless the physician has been trained to understand dysfunctions of the personality as well as those of the body, he will be lost when confronted by this child and his headache and by many of the cases I will discuss later.

What will the physician who has not been trained in understanding personality dysfunctions—neuroses, psychoses, and behavior disorders—do for the treatment of this child? He will be as baffled by the problem as would be a layman called upon to help a person suffering from acute appendicitis. And because he is baffled, he is likely to say that there is nothing wrong with the child or to consider him a malingerer. On the other hand, if he has been trained in understanding personality dysfunctions, he will begin an intensive and painstaking investigation of the child's emotional life—his fears, loves, hates, and ambitions and

the methods he uses to express or refrain from expressing these feelings.

I do not think anyone will question the desirability of every physician's being able to understand a case, child or adult, involving physical suffering, even though the cause of the suffering is not due to an organic disturbance. In fact, so much is the study and treatment of these disorders considered the function of the physician that a few years ago a medical journal (*Psychosomatic Medicine*) was inaugurated for their special consideration. Children particularly express their emotional upsets—which result from their unsolved intrapsychic conflicts and from the conflicts that arise between them and their environment—in symptoms that appear to be disturbances of physical functions. On the other hand, many children suffer from forms of neuroses, psychoses, and character disturbances that do not appear as disorders of physical function. Is the understanding of such cases really the duty of the physician? If the physician does not think this is part of his duty, the layman does, for more and more he consults him for the diagnosis and treatment of psychoses, neuroses, and character disorders whether associated with physical symptoms or not. Also, careful scientific researches are constantly revealing new data as to the importance of disorders of the feelings—fear, love, and hate—in the production of dysfunctions both of physiology and of conduct.

If the physician desires truly to fulfill his professional role of aiding human suffering, he must be as well equipped to deal with the suffering caused by emotional illnesses as with that caused by organic illness. To do this he should know as much about emotional disorders, as they affect both children and adults, as about those organically produced. It is especially important that he understand the emotional illnesses of children, since then he will be able to institute measures that may prevent the later occurrence of emotional illnesses in adult life.¹

The physician has always received some training in the syndromes, psychopathology, and diagnosis of the major psychoses and neuroses. These conditions form outstanding examples of various mechanisms underlying all human behavior, and from their study we can learn much about the dynamics of the mind. However, because they appear in such marked forms in the severe psychoneuroses and psychoses, it is difficult at first to be able to see the same dynamics at work in the milder

¹ Gerald H. J. Pearson: "Training of the Medical Man in Child Psychiatry," *Handbook of Child Guidance*, edited by Ernest Harms, Child Care Publications, New York, 1947, p. 333.

psychoneuroses and in so-called normal people. Such an understanding comes through much experience in psychiatry and therefore is not available to the physician who has not specialized in this field. The physician who has not specialized in psychiatry, and specifically in child psychiatry, tends to study and consider his little patient from a rather limited standpoint. He sees him as a case of headache rather than as a child who is an entity and whose behavior in all the aspects of his life, including his headache, presents evidences of his attempts to adjust his personality to what he considers to be the requirements of his life.

The patient comes to the physician with a feeling of ill-being, manifesting itself in the various aspects of his life, in the hope that the doctor will remove that feeling and restore one of general well-being. He sees little or no connection between his headache, his schoolwork, his unwillingness to conform, and the disagreeable atmosphere of the home. He may say that his schoolwork and parents are a headache, but he is not aware that what he says is true—that they really are *his* headache. The parents little realize that the child is an integral part of the family group and that his various symptoms may be connected with their marital problems. Because they do not understand these connections, they may not mention all the problems to the physician; but they do expect him to help them, and therefore it is his obligation to make inquiry into the various aspects of the child's life.

I realize that such an inquiry takes a great deal of time. It cannot be made in less than five or six hours, and it often takes much longer. This is considerably more time than the busy general practitioner or pediatrician may wish to spend on an individual case. If he feels this way, he should examine the child carefully to exclude the presence of an organic disease and then refer him to a psychiatrist who is willing to spend the time necessary for a careful investigation. In addition, the general practitioner and the pediatrician usually have not learned the skills required to investigate this child's illness, and unless they have learned these skills, they are likely to stir up violent reactions on the part of the patient—particularly if the illness is a serious one, as are most of those described in this book.

The nonpsychiatrically trained physician, whether he practices a specialty or not, should have every opportunity to increase his knowledge of the etiology and psychodynamics of emotional disorders in children, for the more he understands their etiology and psychodynamics, the better he is able to apply such knowledge as a prophylactic measure.

On the other hand, he must realize that his training does not equip him with the special skills required to treat effectively the majority of such cases. I have emphasized these two concepts here and consider them so important that I emphasize and re-emphasize them throughout this book.

I began this chapter by citing the case of a child who suffered from a headache, from an inability to use his intelligence to its fullest capacity in learning his work at school, and from unconforming behavior. Such a case presentation is a description of symptoms. The method of discussing the psychopathology and treatment of the symptoms for which the child is brought to the doctor is the one used in the books on child psychiatry at present available—Kanner,² and English and Pearson.³ The method does not correlate the field of child psychiatry with that of adult psychiatry—the various clinical syndromes of the neurosis, their diagnostic criteria, their psychopathology, and their treatment. The student finds a great gap in his thinking between what he knows of psychiatry as applied to adults and what he reads about psychiatry as applied to children, and he has difficulty in bridging this gap because, as far as I am aware, no systematic attempt has heretofore been made to discuss the emotional problems of children under their diagnostic categories.

In the following chapters are described the methods that are desirable in examining such a case as the child we have been discussing, the diagnostic categories in which his case and those of other types of emotional disorders of children belong, and the etiology, psychopathology, and treatment of each type.

² Leo Kanner: *Child Psychiatry*, Thomas Publishing Co., Springfield, Ill., 1935.

³ O. S. English and G. H. J. Pearson: *The Common Neuroses of Children and Adults*, W. W. Norton & Co., Inc., New York, 1937.

CHAPTER TWO

THE METHODS OF STUDYING A PSYCHIATRIC PROBLEM IN A CHILD

WHEN A PARENT brings an emotionally disturbed child to the physician, he wants the latter to institute a method of treatment that will cure the child as rapidly as possible. The physician wants to do the same thing. To do so he first has to determine what is really wrong with the child. He proceeds according to the well-recognized medical procedures: the collection of data concerning the child and his illness, i.e., the child's history and examination; the comparison between that data and the data that would be obtained from a well child, i.e., the psychopathology; and the grouping of the data and its comparison with the data known to indicate the various forms of illness, i.e., the diagnosis. Then he can consider the measures that will help restore the child to health and how to employ them, i.e., treatment. This is well known as the medical approach and might seem a waste of time even to refer to it, if it were not for the fact that many physicians who would no more think of prescribing treatment for a child's organic illness without examining him carefully are quite willing—when the parent asks what to do about the child's, say, temper tantrums—to give advice at once without making any investigation into the causes of the symptom.

The examination of the child presenting an emotional problem proceeds along exactly the same lines as in the case of an organic illness: the history is taken and the child examined. But here the history and the examination include a wider range of investigation than are in-

volved in an organic illness. In the examination the eyes and ears of the physician are the most important examining instruments, but special technical measures may also be necessary. How is the examination conducted?

CASE 1. A mother refers her ten-year-old daughter because she wets the bed at night. How shall we proceed? As always, the first step is the taking of the history. How is this done, and what are the data that must be secured?

THE TAKING OF THE HISTORY

(It is advisable that the parent come without the child for the history interview,) for with the child present neither parent nor doctor is quite free to discuss the child and his history. Besides, the child may become annoyed or frightened by some of the discussion. Or if he sits for an hour in the waiting room while the parent and doctor are having the history interview, he tends to become bored, to wonder what terrible plans are being made for him, and to become frightened. All this unnecessary emotional turmoil is avoided by having the parent come alone.

(Although there are certain questions to which the doctor requires an answer, it is better to start a history interview by asking the parent to tell all she knows and can think of about the child and his symptoms. With this general question and a little encouragement, the parent will usually launch into a description of both. This description will be infinitely more reliable and valuable than a history obtained by the question and answer method.) As long as the parent continues to talk, there is no need to interrupt except to ask for the dates of the various events she is describing. When the parent has related all she can, the doctor can ask any questions that remain unanswered. (Through this method not only will the history be more reliable but the doctor will get more valid impressions as to the attitudes of the parents toward each other, toward the patient, and toward the other children in the family. The patient's history should be *recorded* chronologically and should include a description and history of the presenting symptoms.)

THE HISTORY OF THE PRESENTING SYMPTOM

(Often there is one presenting symptom for which the parent brings the child. In this case it is enuresis, or bedwetting. The first thing we have to know about the enuresis is the time of occurrence and its history,

the attitude of the patient and her family toward the problem, and what methods of management have already been used. It occurs every night while the child is asleep. It began when she was six years old, without any apparent cause, and has continued almost uninterruptedly since. Occasionally she has a dry night. She does not wet in the daytime. She has no urgency, frequency, or pain on urination. She feels very ashamed and embarrassed when she awakens and finds that she has wet herself and feels particularly overwhelmed with shame at the thought that her *father* might know about it. In fact she does not want anyone to know that she has enuresis. Once she became panicky when, because she had an appointment with a doctor, she had to ask permission to be excused before the school session was over, dreading lest the teacher ask her the reason she had to see the doctor. The parents have dealt with the bed-wetting by all the usual methods. When it first began, the mother was surprised but thought that it would stop in a few days. Since it did not, she insisted that the child get up during the night and empty her bladder. Then she punished her, by scoldings, deprivations, making her wash the soiled linen, and occasional spankings. All these methods proving ineffectual, she took the child to a doctor, who examined the urine, found it showed no abnormalities, and gave her a medicine combining alkalies, to make the urine more alkaline, and belladonna. This had no effect, so another doctor was consulted, who suggested that all fluids be prohibited after 4 P.M. and that a calendar be kept to which a gold star would be affixed each day that the child did not wet her bed. There was to be an extra large gold star for each week during which no bedwetting occurred. She never attained a large gold star. This, then, was the history of the presenting symptom, the methods of treatment that had been used, and their results.

I have seen cases of enuresis treated by various techniques. It is commonly said that children wet the bed because they sleep so heavily, and in recent years attempts have been made by the use of benzedrine to cause the child to sleep more lightly. Since he is more easily awakened he gets up and goes to the toilet, and *therefore the bed does not get wet*. Atropine, belladonna alkalies, restriction of fluids at bedtime, waking and taking to the toilet, star charts, apparatuses that ring the bell when the child starts to wet the bed, apparatuses that occlude the urethra by pressure, operative procedures such as circumcision and tonsillectomy based on the theory that there is some mechanical irritation that causes the bedwetting—all have been used. It will be noted that all these measures are symptomatic; i.e., they are directed toward stopping the symp-

tom, and in only a few instances is the treatment based even on a theory as to the cause of the enuresis.

(THE INQUIRY INTO ALL ASPECTS OF THE CHILD'S PERSONALITY)

In this case enuresis is the presenting symptom, but it is improbable that it is the only evidence of pathology. It is necessary, therefore, to obtain a complete picture of all phases of the child's activity in order to ascertain the presence of other symptoms. This is doubly necessary because often the doctor notes certain phases of behavior as pathological which the parents regard not only as nonpathological but even as admirable characteristics. Inquiry must be made into all phases of the child's life, his adjustment in school, educational achievement, habitual emotional reactions, fears, habits, and psychological status.)

In the case under discussion we find the following:

Psychological status: Has a few food fads, not unusual ones. Since the age of six has suffered from constipation.

Reactions in the family group: A very good child. With her mother is usually extremely obedient, conforming, seldom objects to what her mother desires. This behavior has been present since the age of six. Is shy and withdrawn with her father and seems very afraid of him, much more afraid than his behavior to her would justify. This fear began at about the age of five. Is antagonistic and hostile to her six-year-old brother, who, although younger, is already stronger and bigger than she.

Social relations: Shows extreme fear of men. If sent on an errand, particularly after dark, and sees a man walking on the same side of the street, crosses the road and stands in a doorway until he goes by. If the man is accompanied by a woman, does not seem so afraid. Tells me that when introduced to a strange man, feels so shaky inside that she can hardly speak to him. This behavior has been present since the age of five. Expresses quite a derogatory attitude toward boys. They are coarse, dirty, unintelligent, and rough. However, she does play with some boys, and her attitude with them is one of extremes: is either tomboyish and has to surpass them in everything or sits on the sidelines and watches them, feeling they do not like her. Has one close girl friend. Does not like other girls, but hides this dislike under snobbishness. According to her the other girls in the neighborhood are not of her class and she looks down on them. As a result of this attitude, her colleagues, who really are her social equals, do not like her and tend to exclude her from their companionship.

Reactions in school: Does extremely good school work, usually at the head of her class. Her behavior is almost perfect. Strives hard to maintain this position and does a great deal of extra work. If not first, becomes very upset, anxious, and frightened.

Habitual emotional reactions: Outstanding habitual emotional reactions are her temper tantrums. Do not occur often, but when they do are very violent. Usually begin over the question as to which dress she should wear. If her mother wishes her to wear one dress and she wishes to wear another, she objects, cries, screams, lies down on the floor, and kicks. These temper tantrums have been present since the age of six.

Recreation: Has divided her time between two antithetical recreational pursuits: either sits by herself and reads or is boisterous and tomboyish. The former pursuit more common.

Fears. Suffers from nightmares in which she is being pursued by terrible strange men. These have been present since almost the age of five.

In summary, she is a seclusive child, finding her satisfactions in life in exaggeratedly conforming behavior to her mother and teachers, in surpassing all her rivals in school. She suffers from an excessive and unreasonable fear of men, and at the same time despises girls and endeavors to behave like a boy. When this picture of the child is studied, it is plainly evident that enuresis is not her only symptom. In every phase of her life she shows pathological reactions and behavior.)

THE HISTORY OF THE OTHER SYMPTOMS

As in the case of the symptom of enuresis, it is important to obtain the history of the development of the other symptoms.

A chronological table of their development shows interesting material: Age 5 years—she began to be afraid of her father and other men, and developed nightmares showing fear of men. Age 6 years—beginning of enuresis, exaggerated obedience to mother, temper tantrums, and constipation.

Her illness, whatever its nature, symptoms, and subsequent development, seems to have begun about the age of five years.

THE HISTORY OF THE PSYCHOSEXUAL DEVELOPMENT ¹

Having obtained this data, we next obtain the history of her psychosexual development and the story of her life experiences—the acts of

¹ There are five stages in the child's psychosexual development: (1) The *oral stage* begins at birth and lasts till about the end of the first year. During this period the child obtains most of his sensual pleasure from the use of the mouth.

fate, parental attitudes, and excessive sexual stimulations. She was a full-term child, and her birth was normal. She was breast-fed for ten months, and her weaning was gradual. She had no illnesses during the first year of life. Her mother began her bowel training early, and it was completed by the age of ten months. Bladder training was started at the same time as bowel training and was completed for both day and night wetting by the age of eleven months. Her mother was disgusted by the attempts of the child to suck her fingers and severely and promptly stopped it. When the little girl was six years old, her mother noticed that she was touching her genitals. The mother became very upset by this and used great force and persistence to stop it. Every time the child put her hand anywhere near the middle of her body, her mother scolded, threatened, and slapped her. In spite of this, the child persisted for a time but eventually gave in to the mother. Shortly thereafter the enuresis began.

A chronological chart of her psychosexual development, contrasted with the optimum periods of psychosexual development, would be as follows:

	<i>Psychosexual Development</i>	<i>Optimum Period of Psychosexual Development</i>
Weaning	10 months	10 months
Bowel training completed	10 months	2 years
Bladder training in daytime completed	11 months	2½ to 3 years
Bladder training at night completed	11 months	3 to 3½ years
Finger sucking	not allowed	1 to 2 years
Masturbation	stopped about 6 years of age	never stopped

He uses his mouth also as the organ by which to make contact with the environment. (2) The *anal-sadistic stage* begins at about the end of the first year and lasts until about the age of 2½. During this period he obtains most of his sensual pleasure from his excretory activities and from being cruel. He uses his excretory activities as the main means of making a relationship with the environment. (3) The *phallic stage* begins at about 2½ and ends at about 6 or 7. During this period he obtains most of his sensual pleasure from his genitals. It is during this period that he passes through the Oedipus situation. He has passionate erotic desires toward the parent of the opposite sex and conflicting feelings of love and hate toward the parent of the same sex. (4) The period of *sexual latency* begins at about 6 or 7 and lasts till about 11 years of age. (5) *Adolescence* begins at about 11 and lasts through puberty and until adulthood is attained.

Those readers who are not familiar with these concepts of the child's development are referred to *Emotional Problems of Living*, by English and Pearson, and to Chapter II of *Common Neuroses of Children and Adults*, by the same authors.

A glance at the chart indicates that the child's stages of psychosexual development—finger sucking, bowel and bladder pleasures, and masturbation—were all severely curtailed by the mother, as compared with the optimum period of enjoyment of these pleasures. Such a curtailment imposed an unnecessarily severe conflict between her instinctual desires and her wish to please her mother. As a result of the conflict, she came to feel that her instinctual desires were dangerous, since they made her feel insecure in her relationship with the mother. (Since infantile libidinal desires are the precursors of later sexual desires, such conflicts can injure a child's later sexual development.)

(THE HISTORY OF TRAUMATIC EVENTS)

Having investigated the history of the psychosexual development, we must next inquire into the history of traumatic events. What is meant by the phrase "traumatic events"? The child has certain needs, which may be summarized as follows:

1. He needs the security and backing of two present parents.
2. He needs their love and understanding.
3. He needs an optimum period of gratification for his infantile sensual desires. It is generally agreed that it is best for the development of a child that he be breast-fed for a period of eight to twelve months, his bowel training take from eighteen months to two years, his daytime bladder training take from two and a half to three years, his nocturnal bladder training take from three to three and a half years, and that his finger sucking and masturbation not be interfered with. These various periods of training are known as the periods of psychosexual development that are optimal—or best—for the child. These periods should not be too curtailed; on the other hand, neither should they be allowed to exist too long. If a period is too brief, the child suffers too much painful anxiety when it comes to an end. If it is too prolonged, he does not learn how to tolerate anxiety and when the gratification necessarily has to end, the amount of anxiety experienced is again too great. A child has to learn how to tolerate anxiety, but he has to learn to do so through minute doses.
4. He needs opportunities to express his hostilities, antagonisms, and aggressiveness so that he may learn what these feelings are like and how to deal with them efficiently.

All children, also through the conflicts of their postnatal development, develop three fears—a fear of being deserted, a fear of not being loved, and a fear of being mutilated. They regard desertion, lack of love, and

bodily mutilation as the punishments they will suffer unless they behave in ways that will please the parents.

Anything that prevents the effective satisfaction of the child's psychosexual needs or that increases the fears mentioned above will have a deleterious effect on the development of the child's personality and is likely to produce an illness. Such occurrences are known technically as traumatic events, i.e., events that are injurious. They can be grouped into three classes: (1) acts of fate, (2) adverse parental attitudes, and (3) exposure to premature and excessive sexual stimulation.

1. Acts of fate. The child needs the security and backing of the visible presence of two parents—a father and a mother—in order to solve the problem of his conflicting feelings toward them. If a parent should be absent because of death, marital separation, or other necessary cause, the even developmental progress of the child's emotional life is severely affected. It is interesting to observe that still another form of separation or change has a traumatic effect, though to a lesser degree: change of residence. Another act of fate that may seriously interfere with the child's development is the occurrence of frequent, prolonged, painful or crippling illnesses. Still another that may have a traumatic effect on the child's development is the birth of a new sibling.

2. The effects of adverse parental attitudes. The observant reader will have recognized that not all parents are wise in the handling of their children. Also, that not all parents feel the same way toward their children and that a parent does not feel the same way toward each of his children. He will know that the concept that parents universally love their children is a fiction—a theory unsubstantiated by fact. The feelings of parents toward their children form a graduated continuous scale, starting from the parent who *really* loves his child and ending with the parent who really *only hates* his child. Since parental love is so necessary for the child and the reasons are self-evident, I will mention only the adverse parental attitudes, i.e., those in which some serious degree of hate is present. Realizing that there is a graduated continuous scale, it seems necessary for purposes of presentation to classify adverse parental attitudes into three groups: (a) rejection of the child; (b) overprotection of the child; (c) indulgence.

Similarly, parents who have adverse attitudes toward their children may be classified into three types: (a) overstrict parents; (b) overstrict parents who feel guilty about their dislike of the child; (c) weak parents.

3. The effect on the development of the child of too early or too excessive sexual stimulation. Over half a century ago, Freud was sur-

prised to find from the psychoanalytic investigations of his patients that there is as active a sexual life in early childhood as exists after puberty. He was impressed by the frequency with which sexual seductions by adults and older children occurred in the early childhood histories of his patients, and also by the fact that neurotic symptoms seemed to start shortly after these episodes. In many instances, he was able to corroborate from other sources the fact that these episodes had actually taken place, although later he was forced to reach the conclusion that many of the uncorroborated episodes might have been only the fantasies of the little child. It is generally agreed, and from my experience amply proved, that actual sexual seductions have a profound effect on the child's development.

The Psychic Effects of a Traumatic Experience

What are the effects of a traumatic experience? In a series of cases of children who show symptoms of a neurosis, one finds that they fall into two groups: those whose neurosis started at a definite time and those whose neurosis seems to have been present from the beginning. In the first instance it is always found that the neurosis follows one or more traumatic experiences, all occurring about the same time. In the second, one finds that mild traumatic experiences have been the child's lot throughout life. The more severe the traumatic experiences, the more severe the neurotic illness.

What course does the child's development take after a traumatic experience? Since such an experience arouses intense feelings and strong emotional reactions with which the child is unable to deal, he will first feel anxious and helpless; i.e., he will have an anxiety attack. This in itself is painful, and in order to avoid the pain he will go through certain maneuvers. He will try to forget, i.e., repress, the memory of the traumatic experience, the feelings engendered by the experience, and the feelings, thoughts, and desires that seem to him to have produced the experience. In order to keep the painfulness of the traumatic experience repressed and to avoid doing anything that might cause its repetition, he may try to avoid all situations or actions that remind him of what he has repressed. In technical language, he will impose inhibitions on himself.

The repression, when reinforced by the inhibitions, tends to break down when circumstances arise that either cause an increase in the child's instinctual needs or force him further to repress his needs. When the repression begins to break down, the repressed material begins to

reappear in consciousness. Perhaps the repression of the impulses and ideas remains effective, but the feelings of fear break through. He will then suffer from recurrent anxiety attacks and be unable to understand what he is afraid of. Instead of feelings of fear, his feelings of guilt may break through, and feeling guilty without knowing why, he may be forced to behave in an overconscientious manner so as not to add to the guilty feeling, or he may seek to assuage his guilty feelings by overt naughty behavior that will cause him to be punished. If the repression of the underlying impulses breaks down, the impulses dare not seek their usual form of gratification lest he re-experience the pain of the traumatic situation. Ordinarily in a situation involving the frustration of inner impulses the attempt is made to find new methods of satisfaction. But any attempt to find new methods is banned by the fear that to do so would lead to a repetition of the traumatic situation. Under these circumstances, the inner desires have only one course, i.e., to flow backward and seek earlier and now relinquished modes of expression.

Which of these modes will the impulses find most ready to undertake the task? In the life of most human beings, the course of development is not an even one. For example, if the child has had a very short nursing period, he will unconsciously still be desirous of obtaining complete oral satisfaction; i.e., the oral zone will remain energized to a greater degree than in more fortunate children. These energized but unconscious oral desires will constantly be attempting to obtain gratification and will have to be held in check by strong repression. The strength of this repression is just able to hold the oral needs in check. So the defenses necessary for the child's development are relatively weak at this point. When at a later period other instinctual drives are frustrated and have to be repressed because of fear of repeating the traumatic situation, the energy will revert to the oral zone. This energy added to that already there, which has been held in check with great difficulty, bursts through the barriers of repression and the child attempts to find satisfaction from the use of the oral activities. This phenomenon is known technically as *regression*, by which is meant that the individual attempts to obtain gratification in a way that he found most satisfactory when younger. For example, although he has long since given up finger sucking, he now reverts to it. Finger sucking is a perversion, which is the use of an infantile form of obtaining sexual gratification at an age when sensual gratification should be obtained in a more adult way.

If he feels a strong antipathy to obtaining gratification through a perversion, he may begin to show disturbances in the usual uses of his mouth. The attempt at gratification shows itself in a *disturbance* of oral function, since by the time the child attains this more advanced age he may have learned forcibly and definitely that it is not proper to use his oral zone as a means of obtaining this type of gratification. He therefore cannot extract pure pleasure from this gratification but has to feel pain in order to bribe his disapproving conscience. It is as if he said to himself, "Look here, you are too grown up really to have pleasure from a babyish method of gratification, so if you want that mode of gratification, instead of having only pleasure you will also have to suffer pain for your desire to be babyish. Each time you wish to gratify your sensual impulses by taking something into your mouth, you will vomit or feel nauseated just to show you that you shouldn't be such a baby!" This attempt to obtain gratification of an inner impulse in a childish way, and the punishment for attempting to be a baby again, forms the basic structure of all symptoms.

As noted above, energy will remain attached to an infantile sensual zone if there has been frustration of the optimum period of gratification. However, it will also remain attached if the pleasure of this type of gratification has been allowed to continue too long, i.e., in connection with the oral zone if the child has been nursed over a long period. This attachment of desire to a zone through which the infant normally experiences gratification because of too little or too much gratification, and which lasts long after the time when such modes of gratification have been relinquished, is known as a *fixation* on that zone. If in later life the individual experiences a severe frustration, he will tend to show neurotic symptoms connected with that zone.

These are the main methods of reaction to a traumatic situation. However, as the child begins to use one or the other he has to develop modifications of them in order to get along better in life. Besides these modifications, he often combines several different methods of reacting, until his neurosis develops a very complicated structure which often requires a long, painstaking piece of work to unravel. I have felt it necessary to introduce at this point the concepts of traumatic situations and the reactions to these situations by anxiety, repression, inhibition, formation of guilt, regression, perversion, and symptom formation because not to do so would make the discussion of the emotional illnesses very complicated and difficult.

The Patient's Traumatic Experiences

To return to our patient. What have been the traumatic experiences in her life? We already know about the mother's strictness in regard to infantile sexual behavior, which caused the child to feel insecure with her. This need not necessarily reflect the mother's attitude toward the child but only to the sexual act itself. The child, however, would feel it as an attitude toward herself and so become insecure. The patient was the mother's second child, the first having died at the age of two and before the patient's conception. The mother was very fond of the older sister and felt heartbroken when she died. When the patient was born, the mother was very apprehensive lest she too die, and so curtailed many of the activities natural to the small child. The constant attention that such looking after required was very pleasurable to the little girl. When she was four years old, the mother became pregnant and, on parturition, turned all her concern away from her daughter to her son. The daughter was left to fend for herself, while the son was over-protected and received all the attention. Turning from giving the patient all her attention, the mother behaved as if it were a trial to give her any attention at all. This change in attitude made the little girl very unhappy, and she turned her attention and love from her mother to her grandfather. He was very fond of her, but after a few months he became ill and died. Again the child was lonely, unhappy, and frustrated. The father had been as engrossed with his daughter and as attentive to her as the mother and had undertaken a great deal of her physical care. (It is not certain whether the mother resented this, but I am inclined to think she did, since after the series of events about to be described, she constantly cautioned the child to be good and quiet and not to do anything to offend or upset the father. There is no evidence that the father was an irritable or easily upset man at this or any time. I feel that this cautioning by the mother was an unconscious attempt to turn the little girl against her father.) The parents built their new house and had their third child because the father's business was prospering. His increased prosperity made him an important person in the town, and he was invited to take part in political and civic affairs. Whereas formerly he was seldom out of the house in the early evening, or on week ends or holidays, he now was busy and away from home practically all the time. The child, not realizing that his activities were responsible, felt that he stayed away because he did

not like her. Thus, in the short time of one year, i.e., between four and five, the attitudes toward the child of three different persons changed from ones that had been satisfying and pleasant to ones that were unsatisfying.

As to sexual stimulation, it is important to remember that the parents are seldom able to tell whether a child has been subjected to excessive sexual stimulation. Probably such information can be obtained only from the child. It was so with this girl. After several meetings it was discovered that when she was about four and a half she heard a noise in her parents' bedroom. She had got up to investigate, and peering in, she observed her parents having intercourse. She did not know what was happening and became very frightened because in the dim light she thought she saw her father attacking her mother. She heard her mother's quick breathing, which seemed to her like groans, and she saw her father's nude body, on which, according to her description, the hair was like the hair on an ape. When she overcame her shock at the sight, she crept back to bed and tried not to think of what she had seen. The next day she felt very afraid of her father, and this fear continued.

It must not be expected that the history taken during the first or first few interviews will be at all complete. As a matter of fact, an accurate history of a psychogenic illness can be given only after the illness has been cured. This is inherent in the illness, which consists of an attempt on the part of the patient to avoid remembering and so knowing the painful experiences that have caused him to alter his psychological adjustments to his real life.

This little girl had suffered all three types of traumatic experiences, and most of them occurred during her fifth year. If we now tabulate these events and combine them with the table of the chronological development of her symptoms, we obtain a very clear picture of the development of her illness.

Age 4. Mother becomes pregnant and a brother is born. The grandfather moves in with the family when they move to a new house. He is very fond of his granddaughter but becomes ill and dies. The father's business and civic responsibilities and interests increase and he is absent from home a great deal. The child sees parental intercourse.

Age 5. Child begins to be afraid of her father and other men, and develops nightmares showing fear of men.

Age 6. Mother forcibly stops child's masturbation. Enuresis, exaggerated obedience to mother, temper tantrums, and constipation begin.

A glance at this table shows a fascinating picture. Between the ages

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of four and five the girl suffered a series of traumatic experiences. These were followed shortly after the age of five by the first symptom of her illness, which was not enuresis but fear of men, nightmares showing this fear, and an increase in infantile masturbation. These had not been recognized as symptoms of an illness. The mother, however, became provoked by the increase in her daughter's masturbation and stopped it shortly after the child reached the age of six, and within a short time the other symptoms, including the presenting one, enuresis, appeared. None of these except the enuresis were recognized by the parents as symptoms.

The important results obtained by such a method of history taking are apparent. It is the method that should be used in the investigation of all cases, and its results, even if not as striking as in this case, are important enough to justify the expenditure of much time with the parents solely to obtain the history.

THE PREPARATION OF THE CHILD FOR THE EXAMINATION

Having taken the history, we now arrange with the mother when to bring the child to be examined. A wise mother will ask how to tell the child why she is being brought to the doctor. This question does not arise so often in connection with a presenting symptom such as enuresis, but frequently arises when the presenting symptom seems to the parents not so much a medical problem—poor schoolwork, shyness, timidity, etc., when the child appears to be unaware of having a problem, as often occurs with character disorders such as seclusiveness, asocial behavior, or antisocial behavior such as stealing, truancy, etc. I feel it is important that the parents tell the child the truth. (It is interesting to observe how often they do not want to do so. They prefer to tell the child that they have a nice friend, the doctor, whom they are going to visit and perhaps the child would like to come along and visit him, too. What the child thinks about such an explanation is readily imagined.) The mother should tell the child that she is worried about the symptom—enuresis, shyness, antisocial behavior, or whatever it may be; that she knows the child is worried about it and would like to be cured of it; that she has arranged for a doctor who specializes in the treatment of such illnesses to examine the child with the hope that he can learn the cause and institute adequate treatment; that the child will not be hurt, humiliated, or punished in any way; that she expects the child to tell this

doctor all he knows about himself and his family. Although in some cases this approach upsets and frightens the child, in the long run it works best.

THE EXAMINATION OF THE CHILD

The purpose of examining the child is to determine his physical, intellectual, and emotional status—in short, to know what kind of child he is and wherein he differs from the normal child. In psychiatric work a knowledge of the child's emotional status is extremely important; therefore the physician must avoid doing anything that will cause the child to react emotionally in a way that may obscure his real emotional status. All children are afraid of adults—particularly strange ones. They are especially afraid of doctors, who have mysterious powers and knowledge and who often do things that are painful or unpleasant. And especially frightened is the child who is already suffering from an anxiety state, or who feels guilty about some secret that he does not wish anyone to know, or who has been a bad child and expects that he will be punished. (Frequently adults in analysis will state that they were taken to a doctor during the latent period of childhood or in early adolescence for some obscure complaint—probably some expression of anxiety—and were panic-stricken before, during, and after the visit. They would tell the doctor nothing, would answer none of his questions, and even resisted any type of physical examination. In every case the real facts were that they had been masturbating and were in a state of panic lest the masturbation be discovered.) He will also have more fear if his parents have used his approaching visit to the doctor as a threat in order to induce conformity: "If you continue to suck your fingers, I will tell the doctor and he will cut your fingers off." Realizing that any one or more of these situations may be present, the physician must consider carefully how and when to approach the child in order that the situational emotional reactions may not be so increased as to render the examination valueless.

Where should the child be examined? The pediatricist or child psychiatrist or general practitioner who sees a large number of children should possess a playroom. This can be any small room and need not be elaborately furnished. A kindergarten table, one or two small chairs, a cabinet to hold toys, a sandbox, and a blackboard are all the necessary furniture. The floor should be bare or covered with linoleum. If

a low basin or faucet—with a master switch whereby the water can be cut off if necessary—is available, so much the better. The toys should be inexpensive and thus easily replaced if broken, and should comprise a male and a female adult doll, a boy and a girl doll, a baby doll, a bathtub, basin, and toilet, blocks, several autos, airplanes, engines, boats, pistols, cannon, soldiers, a set of dishes—best of metal—plasticine, paints, crayons, chalk, pencil, and paper. Only under unusual circumstances are other toys required. The playroom should be so constructed and furnished that the physician can relax and not be constantly apprehensive that the child will injure some valuable article. If a playroom is not available, it is wise to have a few toys in the office.

THE ESTIMATION OF THE EMOTIONAL STATUS

In what order should the examination proceed? Since the most difficult part is the estimation of the child's emotional status, it should come first, followed, if necessary, by the estimation of the child's intelligence. The physical examination—the most frightening part to the child—should be left to the last. Let us take these three examination procedures in turn. I was introduced to the girl whose history I had taken and asked her to come with me. She did so readily, indicating how early in life the child learns conformity to the wishes of adults, without regard for his own wishes and emotional reactions. (If the child refuses to leave the parent, the latter may accompany him to the playroom. In most cases when the parent must accompany the child, the parent can leave the child at the door. Only occasionally does the child demand that the parent enter the playroom. The parent can stay at the door a few minutes and then leave, regardless of the child's protests. All of this behavior, of course, is an indication of the child's emotional status and so should be recorded.)

It seemed to me that the following procedure was the most desirable for a child of the age of this girl: After we were alone in the playroom, I invited her to sit down and said I would like to talk to her for a few minutes. Then I told her that I was a physician who specialized in helping people who were upset, worried, and frightened. I cited a number of cases of children whom I had been able to help, and included among them was one that resembled her. I told her I would be able to help her best if she could tell me all about herself so that I would know as much about her as she did. Then I reassured her on two counts: no matter what she told me about herself, I would not criticize her and

I would not tell anything she told me to her parents or to anyone else unless she wanted me to.² I told her that some children prefer to talk; that others find it difficult to do so, so I had toys with which she could play because I found that as a child played, he often dramatized the things that were worrying him, and then if I could understand the dramatizations, she and I would talk about her worries. For the remainder of the time we were together, she could do as she liked. Everything she produced after this was important, since what she said and did represented her reaction patterns and often indicated the causative factors behind the reaction patterns. It might not be possible at this point to say what her type of play or conversation meant with respect to the causative factors, but this was not important at the time. More important was an estimation of her reaction patterns, i.e., of the kind of child we had to deal with. If the child is a young child, under six years of age, such an explanation is not so necessary because usually on seeing the toys he will want to play with them. The purpose of this explanation is to gain rapport with the child on an honest basis, i.e., one connected with the real purpose of the child's visit, so that the child cannot suspect that he is being tricked.

What did the girl do? She sat very quietly and seemed to listen with great attention, although her eyes strayed around the room from time to time. As she sat, there was a slight but visible tremor of her hands. When I had finished, I asked if she had any questions she would like to ask me. She said no. She continued to sit without moving, and since I saw she was frightened, I asked her if she liked to draw. She said yes, so I got her paper and crayons. She asked me what I wanted her to draw. I said I would like a picture. After some hesitation, she began to draw a geometrical design very meticulously. She spent the rest of the time doing this.

Perhaps you will say this was a wasted hour. Let us look to see what I learned about her during it. In spite of my explanation, she did not respond even to the point of telling me about her symptoms. Perhaps she acted this way because she thought I knew that she wet the bed, but her response probably was due more to her shame and embarrassment about the enuresis. She was also visibly afraid—of me. She trembled a little and did as I suggested only in order to please and pacify me, another demonstration of her suspicion and fear of me. If I had asked her a number of questions, she would have responded with answers

² I meant what I said, and in every case I earnestly try to live up to my promise, regardless of the pressure that the parents or other adults may bring on me.

she thought would please me. She drew designs instead of the picture I asked for because there would be less for me to criticize or ridicule in a design, feeling intuitively that a design would reveal less of herself than would a picture. The interview, then, corroborated the testimony of the history—an embarrassed, inhibited girl who was frightened of men.

This interview is not typical of first interviews, so I will cite another, more dramatic one.

CASE 2. A girl of seven came to the playroom with only mild hesitation, bringing her purse with her. After my explanation of the technique for the interview, she told me that she used to wet the bed when she was three years old, but not at present. (She did wet the bed at present, although this was not her presenting problem.) She walked to the sand table, picked up a toy soldier and buried him in the sand. She selected eight soldiers and made a high pile of sand. She got on the sand table, tramped on the eight soldiers, and buried them deeply and forcibly in the pile. Her dramatization indicated a great deal of aggressive feelings but I had no right to theorize even by way of mild speculation as to what the play depicted. (In the course of treatment she verbalized her hostile feelings toward the seven members of her family and toward her teacher, and retrospectively I felt that these were the eight people whom she wished to destroy and get rid of, as expressed in her actions in the first interview.)

THE ESTIMATION OF THE INTELLECTUAL ABILITY

The second part of the examination is the estimation of the child's intellectual ability.

It is desirable in most cases to have an accurate estimate of the child's intellectual ability. Only if the description of his physical development and symptoms—difficulties with schoolwork, etc.—indicates that there may be intellectual retardation is such an estimate needed. This is done best by a competent psychologist, who knows how to use the standard tests of intellectual ability.

Special care should be taken—especially if there is an apparent unevenness in the child's development—to avoid the sadly common practice of gauging the intellectual capacity by the result from a single test, however good that test may be or however expertly administered. Differences of considerable magnitude may on occasion be discovered among test results for a given individual. these differences are often of major value in diagnosis.

The tests most commonly used are the following:

1. *The 1938 Revision of the Stanford-Binet Intelligence Test.* The most widely used intelligence test is the Terman-Merrill Revision of the intelligence test first developed by Binet. Although applicable to adults, the test was standardized on children and adolescents. Intelligence quotient and mental age are obtained by the test. The so-called "scatter," the kind and number of problems the patient is unable to solve, has proved to be of diagnostic importance. The diagnostic indications obtained appear to agree with the findings of the personality tests and have proved valuable in the differential diagnosis of mental deficiency and the psychoses and neuroses.

2. *The Cornell-Coxe Performance Test.* This test, the newest of its kind, is nonverbal and hence can be used in cases with speech or language difficulty. It is used to measure practical reasoning and visual-motor co-ordination and is standardized only on children and adolescents.

3. *The Bellevue Adult Intelligence Scale.* This test was developed by Dr. Wechsler and is the first test standardized on adults. It consists of a verbal and a nonverbal part, each of which can yield an intelligence quotient, thus uniting the advantages of the two tests described above. It has been found that the "scatter," the numerical relation of the scores of the ten groups of tasks of which the test consists, has diagnostic significance.

4. *The Minnesota Pre-School Scale.* This test for pre-school children fulfills the same needs that the Bellevue Test does for adults. It consists of a verbal and a nonverbal part.

5. *Chicago Nonverbal Examination.* The age range is from eight years through the superior adult. It yields scores that may be transmuted into M.A. and I.Q. and also percentile rank.

6. *Kohs Block Designs Test.* The age range is from six years through the adult; it yields M.A. and I.Q.

7. *The Carl Hollow Square Scale.* This is designed particularly for use with adult subjects but is usable down to ten-year levels. The results are expressed in terms of M.A., I.Q., and percentile rank.

Then if warranted, the special tests dealing with educational achievement of special abilities—artistic, mechanical, musical, etc.—should be given.

There are other tests of a projective nature that often help in the understanding of the basic emotional difficulties of the patient. These are only aids and should be evaluated as one evaluates a laboratory test—

as a useful adjunct but not as the final word in making a diagnosis. I feel strongly that the results obtained from a clinical examination of the child are infinitely more valuable than those obtained by the use of projective tests. The longer I work with children, the less reliance I place on these tests. I have noticed that beginners in the field use these tests frequently but that as their clinical experience increases, they fall back on them less and less. I mention them here because they seem to be regarded as important, especially by people who have not had much psychiatric training and experience. Osler's old dictum of "eyes first and foremost, hands least and last," to which I would add laboratory methods only as a minor adjunct, still holds good in the practice of medicine.

The projective tests most commonly used are the following:

1. *The Rorschach Test.* The child is shown a series of pictures of formalized ink blots and his responses are scored on an empirical scale. It may be of help in giving information as to the severity of the illness. It may help to decide the difficult question as to whether the presenting symptom, such as a phobia or a series of temper tantrums in a young child, merits intensive psychotherapy. If the result of the test is to be valid, it should be administered and scored only by a trained person.

2. *The Thematic Apperception Test.* The child is shown a series of pictures, one at a time. Each picture portrays an emotional situation, and the child is asked to tell or write the story he sees in the picture. His responses are measured by an empirical scale.

3. *The Despert Fable Test.*³

(1) *The Bird Fable:* to ascertain whether the child is dependent emotionally—i.e., fixated—on the parents or whether he is independent.

A Daddy and Mommy bird, and their little birdie, are asleep in the nest on a branch. But all of a sudden a big wind blows; it shakes the tree and the nest falls on the ground. The three birds awaken all of a sudden. The Daddy flies quickly to a pine tree, the mother to another pine tree. What is the little bird going to do? He knows how to fly a little already.

(2) *The Wedding Anniversary Fable:* to ascertain whether the child may have witnessed sexual intercourse in the parents' room; jealousy toward parents' union.

Daddy and Mommy are celebrating the day when they were married. They love each other and they have arranged a beautiful party.

³ J. Louise Despert: "Psychosomatic Study of Fifty Stuttering Children," Round Table: 1. Social, physical and psychiatric findings, *American Journal of Orthopsychiatry*, 16:100-113, January, 1946.

During the party the child gets up and goes all by himself to the end of the garden. Why, do you suppose?

(3) *The Lamb Fable*: to investigate the reactions to weaning and to sibling rivalry.

In a field there is a Mommy sheep and her little lamb. The little lamb bounces around all day near his Mommy. Every night his Mommy gives him some good warm milk, which he likes very much. But he can already eat grass. One day somebody brings to the Mommy sheep a tiny little lamb who is hungry and he wants the Mommy to give him milk. But the Mommy sheep has not enough milk for the two of them; and she says to the bigger lamb, "I haven't enough milk for the two; you, you are bigger, you go and eat some nice fresh grass." What do you think the lamb is going to do?

To investigate the reactions to weaning alone, do not mention the arrival of the little lamb; say that the Mommy sheep has no more milk and the lamb must begin to eat grass.

(4) *The Funeral Fable*: to investigate hostility, death wishes, guilt feelings, self-punishment.

A funeral is going through a village street, and people ask, "Who is it that is dead?" Somebody answers, "It's somebody in the family who lives in this house." Who is it?

For the child who has no conception of death, tell the fable in the following way:

Somebody in the family took a train and went away, far away, and will never come back. Who is it? (Enumerate the members of a family.)

(5) *The Anxiety Fable*: regarding anxiety and self-punishment.

A child says softly to himself, "Oh, I am afraid!" What do you suppose he is afraid of?

(6) *The Elephant Fable*: examination of the unconscious fear of mutilation and castration.

A child has a little elephant that he likes very much and that is very pretty with its long trunk. One day when he comes back from school, he comes into his room and finds that his elephant has changed. How do you suppose it has changed? And why has it changed?

(7) *Fable of the Child's Own Creation*: to test the possessive and stubborn reactions that develop because of difficulties in toilet training.

A child has made something with clay, a tower, which he thinks is very, very pretty. What is he going to do with it? His Mommy asks him to give it to her. Do you think he is going to give it?

(8) *Walking with the Father or Mother Fable*: to detect the unconscious feelings toward the parents—i.e., the Oedipus complex.

A boy goes to the park for a nice walk alone with his Mommy. They have a lot of fun together. When he comes home, the boy finds that the Daddy's face doesn't look quite the same. Why?

Tell the fable for a girl in the following way:

A girl goes to the park for a nice walk with her Daddy. They have a lot of fun together. When she comes home, the girl finds that the Mommy's face doesn't look quite the same. Why?

(9) *The News Fable*: to test the wishes and fears of a child.

A child comes back from school (or a walk), and his Mommy tells him, "Don't begin your homework right away, I have some news to tell you." What do you suppose the Mommy is going to tell him?

(10) *Bad-Dream Fable*: for a check on the preceding fables.

A child wakes up one morning all tired, and he says, "Oh, what a bad dream I had!" What do you suppose he had dreamed?

The child is expected to reply to the question at the end of each fable.

4. *The Human Figure Drawing Test*. The child is asked to draw first a male figure, then a female one, and the two are studied as to distortions, etc., which may throw light on the child's emotional problems.

All these projective techniques are sometimes used with the older child, seven years to adolescence, as a means of getting him interested in talking and so obtaining rapport with him.

Our patient's I.Q. was 120. No other tests than the Stanford-Binet were done on her.

THE ESTIMATION OF THE PHYSICAL STATUS

The third part of the examination is the estimation of the child's physical status, wherein several points should be kept in mind. It is important to observe whether the child's general health has been weakened by overfatigue, sleeplessness, cold, hunger, other physical privations or avitaminosis. These may be contributing to the disturbed state of the child's emotions or may be the result of the emotional disturbance. Their treatment, except for the avitaminosis, will depend on their cause. If the sleeplessness is due to inadequate, uncomfortable sleeping arrangements, these will have to be corrected. If it is the result of the emotional disturbances, the latter will have to be treated. Avitaminosis will always have to be treated directly.

The physical examination itself should be conducted as carefully as possible in order that the child may not be frightened or angered. It should be remembered that the examination of the genitals and of the throat and mouth should be left to the last and not done at all if the child strongly objects, unless the physician feels they are absolutely indicated. Similarly, laboratory tests should be arranged only if really indicated.

If the physician is the psychiatrist who is going to treat the child, it is inadvisable that he do the physical examination. The handling of his body is construed by the child unconsciously (and sometimes consciously) as the fulfillment of his unconscious fantasies and wishes. He unconsciously regards the examination either as a sexual assault or as an attempt to injure—castrate—him. The close association in his mind between the examination and his fantasies either frightens him or causes him to expect more gratification later. His fear or his expectation makes it difficult for him to verbalize his wishes later, or if he does verbalize them he becomes very angry when his expectations are not fulfilled. These feelings interfere with the success of his treatment.

With the patient, I did not feel it wise for me to do the physical examination because of her fear of men, so I had it done by a woman physician, asking her to pay particular attention to whether she showed evidence of epilepsy, which might be evidenced only by nocturnal enuresis. The child could be having convulsions during the night and be incontinent in the convulsion, the only evidence for the convulsion being the wet bed. In such a case, an electroencephalographic examination might be of value. The results of the physical examination, the electroencephalogram, and the chemical and microscopic examination of the urine were all negative.

THE CONCLUSIONS REACHED FROM THE DATA OBTAINED FROM THE EXAMINATIONS

What has been learned by the examinations? The girl, brought to me as a case of enuresis, presented a series of personality reactions and behavior that are different from those of the average girl of her age, sex, and social situation. These reactions, summed up briefly, indicated that she was trying very hard *not* to be a girl.

Her history showed that the attempt not to be what she was resulted from a series of experiences in her life. As a very little girl she was made the center of attention by both father and mother, perhaps of more attention than was beneficial for her. The mother particularly

not only gave her much attention but made her need more attention by restricting her attempts at being independent lest she do something dangerous and die as her elder sister had. The child could accept these restrictions because of the pleasure of the attention. The situation lasted until the patient was about four years old, when the mother bore a son and began to lavish all her attention on him and to neglect her daughter somewhat. This made the latter feel very unhappy and lonely, and because she saw her mother doing for her brother what she would like for herself, she developed the idea that if only she had been a boy, her mother would continue to shower her with attention. Disappointed by her mother's change of attitude, she felt hostile toward her mother and turned from her to someone else, as her mother had turned from her to her brother. But when she turned to her grandfather and father, she experienced even more disappointments. Her grandfather died, and her father not only turned from her to his outside interests but became a very frightening person because of what she thought she saw in his bedroom. Attack was useless; actual flight impossible. She could, however, flee psychologically by withdrawing to an interest in her own body. For this she got into difficulty with her mother. Actual flight of this nature being impossible, she could flee into unconscious fantasy, the fantasy that she was not a girl but a boy. This she did, her personality reactions being the result of this fantasy.

The aim of treatment, therefore, would be to relieve the child of her fear that by being a girl she will suffer harm and disappointment at the hands of the opposite sex. With this accomplished she will be able to be at ease as a girl with other girls and will not have to minimize her passive, receptive, feminine impulses nor accentuate her active, aggressive, masculine ones with boys and men.

I wish to make very clear that the patient was not in the least aware that she had such feelings or that she had such a serious psychic problem. Thus treatment by a physician not skilled in the technique of making the unconscious conscious would have proved valueless. She could be treated only by a child analyst using psychoanalytic techniques.

CHAPTER THREE

THE DIAGNOSIS AND CLASSIFICATION OF PSYCHIATRIC PROBLEMS IN CHILDREN

IN THE PREVIOUS chapter we discussed the examination of a child whose presenting symptom was enuresis. The fact that she suffered from enuresis no more indicated the structure of her symptom complex than if the presenting symptom had been fever. Enuresis, like fever, can be the presenting symptom of a number of syndromes whose structure and psychopathology are very dissimilar. Let us look at a few cases to illustrate this.

Enuresis is a condition in which a child who has been toilet-trained, or has passed the age when toilet training should be completed, wets himself during the day or the bed at night. Since toilet training is not expected to be complete before the age of three and a half, any wetting done prior to this time cannot be called enuresis, nor can the term be applied to the occasional accident that children have after that time. Neither can the term be applied to the incontinence that is only a minor symptom of some other illness, such as pyelitis, in which the frequency and urgency are so great as to make accidents inevitable. Not included also are all cases of bladder and kidney infection and those few cases where disease or abnormality of the spinal cord or vertebral column, such as spina bifida, may cause a disturbance of bladder function associated with disturbances in the motor and sensory functions of the legs and perineum. As pointed out, nocturnal epilepsy may show itself only

by the fact that the child has urinated in the bed during the night. The child who has enuresis, on the other hand, is a healthy child, without signs of physical illness or symptoms related to a disturbance of urinary function. When his urine is examined, it is found to be free of pathological changes.

The nonenuretic cases are extremely rare. There remain the vast majority of children who suffer from enuresis, in whom no logically scientific physical cause can be found.

ENURESIS FROM LACK OF TRAINING

Any large hospital clinic for child psychiatry will have a number of cases of enuresis referred to it by other departments, many of whom never keep their appointments, or keep only one. On investigation, one finds that the family is not at all concerned with the enuresis. Further investigation shows that the parents have never attempted to toilet-train the child nor are they concerned in doing so. All the children wet the bed, and it is only as they approach adolescence that they gradually begin to toilet-train themselves. In the majority of cases this is because the parents are lazy and indifferent to the restrictions of culture. In a few cases it is because the parents also had enuresis in their childhood and "outgrew" it without anything being done. In a very few cases it is because the mother gets sensual pleasure in attending to the physical wants of little children and is loath to have them grow up. These cases can be classified as enuresis from lack of training. The problem lies not in the child but in the environment.

REVENGE ENURESIS AND ENURESIS AS A SYMBOL OF AN OBSESSIONAL NEUROSIS

CASE 3. A boy aged nine is referred because he wets the bed at night and also wets his clothes rather often during the day. His wetting has continued unchanged since birth and all attempts to toilet-train him have been unsuccessful. So, unlike the case of the girl discussed in the previous chapter, there is no definite time when the enuresis began. The events of his life have not been unusual except for his relations with his parents. From the interview both with the mother and with the boy, who talked very freely, it was plain that he had been rejected by both parents, more by the mother than by the father. From the time he arose in the morning until he went to bed at night he was nagged, fussed at, and

criticized. Often by the time he was ready to leave for school in the morning, boy and mother would be in tears of irritation and rage—not only over the bedwetting but over every detail of the daily routine. The father either took the mother's side or remained aloof. The child had no one to support him against his nagging and unreasonable parents. He had few ways to express his resentment of them. He knew that if he wet his clothes and the bed, he would give his mother extra work and thus annoy her, excusing himself on the grounds that he could not help himself. At first he denied being awake when he wet the bed, but later he said that he often woke at night, and then wet the bed instead of getting up and going to the toilet. The enuresis, therefore, was a deliberate conscious act and was done to take revenge on the parents, particularly on the mother, for their unkind treatment of him. This type of enuresis can be classified as revenge enuresis.

In some cases the child knows that his wetting is done consciously as a spiteful action against the parents. He expresses his revenge in this way because he is either afraid or unable to express it otherwise. In others, the child may be unconscious of the fact that he feels spiteful toward his parents and that his enuresis is a spiteful reaction. Here there has been regression to the anal-sadistic stage of development, the clinical syndrome being one of obsessional neurosis with enuresis as the presenting symptom.

ENURESIS AS A SYMPTOM OF CONVERSION HYSTERIA

CASE 4. A boy of six and a half had the following history. He was toilet-trained before the age of two. When he was three the mother adopted another baby, on whom she lavished much affection. The patient reacted by starting to soil and wet. The mother, much annoyed by this return of uncleanness, scolded and punished him. A friend of the mother told her she was not treating the patient fairly, and when he received more attention from her, the soiling and day wetting stopped, although bedwetting continued until he was five years old. Here the boy is unconsciously saying to his mother, "You give my new brother all your love and interest. He gets more attention than I do. See, I am only a little baby, too, and have to be cleaned and changed as he does." He says it unconsciously because he has repressed his passionate longing for his mother and bitter hostility toward his rival because he fears he will be punished by castration if he allows himself to be conscious of these feelings or to express them. However, besides the organic plea for

the mother's attention, there exists also a certain element of revenge. The child is well aware that the stained clothes add extra work of a distasteful kind for his mother and the maid. Though they complain, he nevertheless persists. One gets the impression that he hears their complaints with a certain amount of glee. This type has perhaps inadequately been called regressive enuresis, since all neuroses are regressive. The syndrome in this case is more accurately one of conversion hysteria.

CASE 5. For about two years a boy has had enuresis both during the day and at night, but mostly at night. A year before the enuresis started, his father died of a urinary illness. Both the boy and the mother were very much upset by the father's death, and the mother and boy started to sleep in the same bed. Careful analysis showed that the enuresis was the result of the boy's unconscious attempt to identify himself with the dead father. He had loved his father greatly, felt very unhappy when he died, and wished he would return. However, his absence brought the boy certain advantages, such as sleeping with the mother, which he would lose if the father did return. The enuresis was a result of the conflict between his desire to get rid of the father, his fear of retaliation by the father for his wish, his love and desire for the father, and his fear that his love might result in his being made a girl. It could be solved if he were his father. He could retain him and at the same time get rid of him. So on the one hand he wanted to be his father because he loved him, and on the other he wanted to be the father because he was jealous of him. These two conflicting motives made him feel uncomfortable and guilty. It is as if his conscience were saying: "You have always wanted to get rid of your father and take his place. Now he is dead and your wish has come true. You will be your father. But your father was kind to you and loved you and you were a very wicked boy to desire to take his place. So now when your wish comes true, you will be punished for your wish by being your father, i.e., by having bladder trouble as he did." He was acting out his conflict somatically. This is a case of conversion hysteria with enuresis.

ENURESIS AS A SYMPTOM OF ANXIETY HYSTERIA

CASE 6. A girl of five had been strictly, severely, and early toilet-trained. She began to masturbate, for which the mother punished her. She continued to do so but did not use her hands. Instead she sat on a rocking horse and masturbated by sliding backward and forward on the

saddle. One day she slid too far forward, the horse tipped, and she was thrown violently against the pommel. The horn of the saddle bruised her urethra, and for a day or two she suffered considerable burning on urination. Since she had acquired the injury during masturbation she dared not tell her parents of her discomfort. She worried a great deal lest she had injured her genitals permanently. Upon inspection she found no visible sign of injury, and so she developed the idea that the injury was hidden inside and would soon burst forth, and then she could no longer hold her urine. She started to have some enuresis, which confirmed her idea. Though she had been hurt, nevertheless she had experienced sensual pleasure, and so began to feel very guilty. Her guilt made her believe that she had been injured in some way and therefore no longer had any physical organ to retain her urine. Unconsciously she felt that she had been castrated as a punishment for her masturbation and for the fantasies accompanying it. As a result of this belief, she made no effort at control and urinated whenever and wherever she felt the urge. This is a case of anxiety hysteria with enuresis as the presenting symptom, the basic mechanism of which is described in Chapter V.

The description of a case of character neurosis with enuresis was described in the previous chapter.

Thus enuresis may be a presenting symptom of a number of different symptom complexes. These are as follows:

1. Epilepsy.
 - (1) Organic.
 - (2) Idiopathic.
2. The result of environmental and cultural errors.
 - (1) Lack of cultural training because the parents have a lower ideal of culture than the average parent has.
 - (2) The parents' ideals of the age at which the child can impose cultural restrictions on himself are erroneous. They feel that he should be cultured before he can reasonably be expected to.
3. A chronic aggressive character pattern. The child is deliberately defying the parents' attempts to train him; i.e., he is expressing hostility toward them.
4. Anxiety hysteria as illustrated by Case 6. The patient reacted to her anxiety by repression and symptom formation.
5. Conversion hysteria as illustrated in Cases 4 and 5. The patient in Case 4 reacted to his anxiety because of loss by love by regressing to an earlier level of psychosexual development. The patient in

Case 5 converted his emotional reactions about his father's death into a physical symptom.

6. Character neurosis as illustrated by Case 1. The enuresis was simply one of many symptoms, the patient having altered her character in order to avoid her feelings of anxiety.

Enuresis, therefore, is a symptom that may appear in six different symptom complexes, the etiology, pathology, and treatment of which will be quite different. Because of the differences in etiology and pathology, and as a result necessarily in treatment, among these various symptom complexes, it seems desirable, as an aid to adequate consideration of a case, to know in what category the case falls—or, in the usual medical terminology, to know what the diagnosis is.

Up to now most books on child psychiatry have been arranged on a symptomatic basis; i.e., the author discusses the various etiologies, pathologies, and treatments of, say, the symptom enuresis. I feel, however, that child psychiatry has developed sufficiently to permit it to come more in line with adult psychiatry.

So far we have six syndromes: epilepsy, environmental error, chronic aggressive character pattern, anxiety hysteria, conversion hysteria, and character neurosis. Five of them are well known, since the syndromes are found in adult psychiatric cases. The category of environmental error is found only rarely in adult life, since the adult usually can and does leave an unpleasant environment, whereas a child usually cannot. These six syndromes, however, do not cover all the emotional disturbances of childhood.

THE CLASSIFICATION OF PSYCHOLOGICAL ILLNESSES IN CHILDREN

The psychological illnesses of childhood can be classified as follows:

1. Direct reactions to present environmental errors
2. Acute and chronic anxiety states
3. Anxiety hysteria
4. Conversion hysteria
 - (1) Conversion hysteria after the phallic phase of development is attained
 - (2) Preenatal conversion hysteria
5. Organ neurosis
6. Compulsion neurosis
7. Perversions

8. Psychosis
9. Character neurosis

The following case is presented for diagnosis:

CASE 7. A girl of six is referred because she wets the bed at night. She will not urinate when taken to the toilet but does so as soon as she returns to bed. She wets two to four times a night. Often she refuses to urinate while the nurse is holding and pleading with her. She wets even in the daytime rather than walk a few steps to the bathroom. She occasionally comes home wet from school. Her bedwetting dates from birth. She has lived in an orphanage since the age of three and a half. She has been whipped and punished to no avail by the housemother, who also has tried to train her by wiping the wet sheets across her face, and who daily tells her what a dirty girl she is in the hope she will improve.

Besides the presenting symptom, the child has an unruly temper, is stubborn, sullen, and impudent. She is active and enthusiastic, but her enthusiasms die quickly. She lies to her mother concerning the nurse and has slovenly hygienic habits. She is obedient but takes her time in obeying. She is afraid of doctors and nurses because they use so many needles. She likes dolls more than anything else. She seems to be trying to improve her schoolwork. She masturbates by pulling the sheets tightly between her legs. She has a poor knowledge of sex for her age. Once she reprimanded another child for dressing in a closet, claiming that her own mother undressed in front of her.

THE HISTORY

She was three and a half when her father, who had cancer when she was born, died. As a result she was placed in the orphanage. Her mother worked in a department store and seldom came to see her. The patient was happy when with the mother. The nurse believed she wet herself when with her mother, although the latter would not admit it. Her housemother was an old maid with no sense of humor or warmth, who felt she was being driven crazy by the child, although she protested the child did not bother her. She sat twisting a handkerchief in her hand while telling about her.

THE EXAMINATION RESULTS

The patient had had no serious illness, but was pale, easily fatigued and weak. Her I.Q. was 106.

The patient told the psychiatrist that she dreamed fairly often; once she dreamed about her mother. She shared a room with two other girls. She liked her roommates and the orphanage. Her roommate frequently teased and scared her by hiding in the room. She liked her housemother. She got many presents for Christmas—clothes, dolls, etc. She had two older half-brothers. The rest of the interview was occupied by her description of her daily routine.

THE DIAGNOSIS

Since this case presents both an environmental and an intrapsychic problem, it is pertinent to a discussion of the question of the application of diagnostic criteria. The patient has suffered two traumatic events—the death of her father when she was three and a half and the separation from her mother at the same time. She is daily exposed to the traumatic experience of living in an institution whose rules are unnecessarily strict and applied by a housemother who has little or no understanding of or feeling for the child. The child is attempting to maintain her psychic equilibrium by mobilizing her hostility. She shows a chronic aggressive reaction pattern in which the main impulses are spiteful ones. She would be diagnosed as a character neurosis, of the anal-sadistic type. If the erroneous environmental situation is continued and its intent really takes effect, the patient will have to suppress her spiteful reactions and then her condition will be a neurotic one, probably of the obsessional type. Before this happens her anxiety will increase and she might go through a temporary period of great feelings of anxiety, in which case the diagnosis would be an acute anxiety state.

CHAPTER FOUR

ANXIETY STATES

CHILDREN are often fearful. They may be frightened because they are in situations with which they really are not able to cope physically and intellectually. Such children have real, present fears. Others may have been conditioned by their former experiences to anticipate injury or pain at the hands of other people. They feel their dread in the present, but it is only a remembered dread from the past. Still other children are afraid of their instinctual desires because they believe these are wrong or because they fear they will be injured as a punishment if they attempt to gratify them.

There is no need to discuss either the problem or the management of the first group. Instead, this chapter will consider the psychopathology and the management of the cases in the other two groups.

ANXIETY STATES DUE TO FEAR OF A REAL ENVIRONMENTAL ATTACK

CASE 8. A boy of nine and a half is referred because he is very fearful. His teacher states that when she calls upon him to participate in a class discussion, he shrinks into himself and trembles. He is shy and reserved with children of his own age. During recess he stands alone and after school comes home by himself and reads or listens to the radio. He seldom plays with other children. Some of them seem to like to come to his house. He allows them to but reads while they play. At home he usually obeys but occasionally refuses. When sent on an errand, he does not refuse, but returns with the task uncompleted. He

does not show defiance openly but rather conducts a sit-down strike when feeling rebellious. He shows a certain amount of activity at home but everywhere else is quiet and reserved. He teases his sister. His mother states that he complains of feeling inferior and also that he is ugly.

He has never been a behavior problem, though his teachers occasionally report that he is mischievous and talks too much. He is reported to have spat water down the stairs on a girl, but he denies it. The fact that he is Jewish does not account for his present difficulty in making friends, since even in kindergarten, where all the children were Jewish, he was asocial. Each time the family moved, he underwent a long period of withdrawal and seclusiveness with occasional episodes of naughtiness.

History. He was breast-fed for only a short period. For one or two months he had a feeding problem, accompanied by diarrhea. He was toilet-trained at about two years, but wet his clothes when excited. He was raised strictly, partly because of the conditions under which the family lived. Before the patient was born the family had lived prosperously in Germany. During the first four years of the patient's life—i.e., the four years before the outbreak of World War II—they suffered greatly under the Nazi persecution of the Jews. The father's business was boycotted and he was arrested several times, being taken from his home in the middle of the night and kept incommunicado for varying periods. During these periods, the mother and children were never sure that they would see him again or that they might not be put in a concentration camp or killed. Their home was attacked and the members of the family, including the patient, were reviled, spat on, and stoned. The patient, of course, had no one to play with. When he was four years old the family escaped from Germany in a very impoverished condition. When they landed in America, the patient—although he knew and could speak English well—refused to do so for a long time. He was subjected to further anti-Semitism. His sister also had trouble making friends in America and complained much about her loneliness.

The father is a conscientious, backward, and shy man. Although well educated (as is the mother) and once a prosperous merchant, he has to work now as a woodworker. His working hours are long and he does not see much of the children. The mother also works full time. They are both too busy to entertain friends. The patient seems most attached to his mother.

Examinations. His health has always been good. He receives good marks in school.

He is a slightly obese, alert, and co-operative boy. He relates the story of his life—his moves from East Prussia to Berlin at the age of two or three, at the age of four to the United States, and at five to Philadelphia. He says his father and his mother work and that their hours are long. He sees his father only one evening a week and on Sundays but does not feel resentful of the fact. He says the children eat breakfast alone. He is to enter the fifth grade. His sister, aged ten and a half, is half a grade ahead of him. He does not know why his mother brought him to a psychiatrist.

His friends are the children in the block. He has no close friends at school and spends his recesses alone. At school he is called "Fatty" and "Balloon-Face" and often gets into fights over this, in which he is always beaten. His failure to win worries his mother. During lunch he and his sister often argue and wrestle. He does not hate her but does not like her, either. She, too, is fat, and the other girls do not like her because she is too slow and cannot run or fight. While at camp he had only two friends. He is much interested in swimming and likes baseball, but does not like basketball or football. Particularly he dislikes being tackled. He feels slightly resentful of the family's poverty. He often has headaches and nausea, especially after getting into a fight or when confronted with a perplexing problem in arithmetic.

Diagnosis. The patient is an intelligent, physically healthy boy who is excessively timid. He has headaches and sometimes feels nauseated. He trembles when called upon in class or when reprimanded for minor infractions of rules. He is shy and has no friends. He does not have a good relationship with other children or his teachers. He sometimes fights, but with little success. Occasionally he wets his clothes. Although his whole behavior indicates that he is a very timid boy, he denies having feelings of fear. This denial may be truthful—i.e., he may be unconscious of his feeling of fear—or he may be aware of the feeling and deny it through shame.

I believe that this boy suffers from a constant feeling of fear and that it is apparent to everybody who knows him.

The Reasons for the Denial of Fearfulness. Fear reactions are more obvious in children because children are more open and less ashamed of their emotional reactions than are adults, who may feel ashamed to allow anyone to observe their fear. Sometimes children are ashamed to admit their fears to themselves or to others, because of the American

tradition, which places a stigma of cowardice on even the reasonable expression of fear. This attitude often forces an individual to expend a great deal of energy unnecessarily, whereas by permitting himself to feel fear he would be in a better position to do something about removing its cause; he could determine whether it was a reasonable reaction to a dangerous situation about which he could do something or whether he was oversensitized to feelings of fear and needed help for this oversensitivity.

There are two main reasons for this social stigma against fearfulness. During the pioneer period it was necessary for people to disregard the age-old fears of the unknown because all of their energy had to be used in dealing with the real dangers of an environment that threatened their existence. A person too much frightened by the common fears of the strange and unknown would not be able to take adequate measures to protect his life from the hostile men and animals of the wilderness. In this situation it was a virtue not to show fear, and this tradition continues to operate even though there is no longer need for it except under unusual circumstances. The second reason is perhaps more important. Many of the fears of the ordinary individual are reactions, not to external dangers, but to inner dangers and impulses that often may not be expressed in their primitive form. He has certain impulses and desires of whose nature and even existence he is unaware, and which he would repudiate if he were aware of them. He likes to think he knows all about himself, that the self of which he is aware is his true self and that he is its master. In addition he tends to repudiate any indication that his ideas about himself are not valid. Consequently, if he feels fear in a situation in which his conscious mind tells him there is no reason to be afraid, he prefers to reject the feeling of fear, or at least act as if there were none, rather than hurt his pride by admitting that his psychic picture of himself is invalid. In order to keep his concept of himself unchanged he confuses fear (which may be a signal that he is in danger from something in his environment that really may be harmful to him) with anxiety (which may be a signal that he is being placed in danger by an inner impulse). The feeling is the same in both instances, but the cause is different. It is often this inability to recognize the intrapsychic source of children's anxieties that causes parents to deal with them so unwisely. This point will be discussed later.

Psychopathology. Our patient's symptoms indicate that he is badly frightened and that he withdraws from all interpersonal relationships in order not to feel afraid. If I did not know his history, I might specu-

late that he was unconsciously curtailing all his activities, including his social life, in order to protect himself against the punishment from his unconscious standards (his superego)—i.e., that he was developing severe ego inhibitions. The possibility of a serious prognosis due to his tendency to withdraw from people because of fear may be increased because he is so intelligent. In other words, he may be able to find such great satisfaction in intellectual pursuits as to feel little need to come to terms with his fears of interpersonal relationships.

Why is he in a state of constant fear? The causes in this case are different from those usually found in cases showing an anxiety state. During the boy's early life, before he was four, he suffered constantly from threats and from actual cruelty by older children and from adults. His parents were undergoing similar experiences, and their fears were reflected back on their children. For years the children had to be under rigid control in order not to get hurt by their Nazi neighbors. The father's arrests upset and terribly frightened the mother, and her apprehension caused her to be overstrict. All these experiences occurred between birth and the age of four—the most psychologically unstable period in a child's life. Whether he was really teased very much here, I do not know, but even a little teasing would hurt deeply, and if other children perceived this hurt, they would tease more. This would remind him of all he had heard and actually knew about persecution and would make him apprehensive lest the former suffering start all over again. He knows also that he cannot expect much protection from his parents because they may be persecuted also; besides, they are away from home so much. It may take him a long time living in a totally different situation to overcome these conditioning experiences, and perhaps he will never be able to do so completely.

In this case the boy was sensitized by brutal treatment in the fairly distant past. Fears of this type may fall into several categories. The child may have reason to be afraid of a particular person, be conscious of it, and be willing to talk about it, in which case the fear is reasonable and treatment is directed toward ameliorating the environment. Or a child may have just cause to be afraid and be conscious of the reason but be reticent about revealing it. For example, if he has a brutal father of whom he is afraid, he may, because of his loyalty, hesitate to tell anyone about the situation. Likewise a child may have suffered brutality at the hands of other children but be reticent about telling anyone, because of loyalty to the group or because they have threatened to hurt him worse if he squeals on them.

CASE 9. A boy of nine is referred because he refuses to go to school. When school is suggested he shows extreme fear, and if an attempt is made to force him to go he hides under the bed, clings to the furniture, and on one occasion deliberately threw himself down a steep flight of stone steps in the hope of injuring himself so that school would be impossible. As a result, he sustained a slight concussion. The parents and teachers cannot account for his fear of school, which began shortly after the fall term opened. The family had moved during the summer, and he was entering a new school. In the course of treatment, he mentions that he suffers from a recurrent anxiety dream of which the following is an example:

Dream: Some policemen took a man into the cellar and tied him up tightly to the wall. Patient was very frightened.

This dream started about six months before his acute anxiety appeared and followed very closely after the following experiences: A group of older boys had tied him tightly to a telephone pole. They left him there, and he remained tied until a friend passed by who released him. When he realized that the gang was planning to tie him up, and during the actual procedure, he was terribly frightened but was too proud to show it. And he would not tell anyone afterward for fear of revenge. When an attempt was made to get him to dramatize the scene by having him tie a doll tightly to a post, he showed extreme reluctance to do so, and even then he could not tie the doll tightly until after a great number of attempts and much encouragement. At first he did not realize the great shock he had suffered from this experience, but later it developed that after it he gradually felt an increasing fear of being with other boys. This fear increased when he moved to a new neighborhood and had to adjust himself to new acquaintances. It is important to note that his parents saw no indication of the boy's fear since he dealt with it by increasingly curtailing his activities. The final necessary curtailment—i.e., his refusal to return to school—was the first indication they had that he was ill, though his illness did not seem to them an attack of fear but a stubborn refusal to attend school. As long as the activity was inhibited, there was no outward evidence of his fear. As soon as pressure forced him to remove the inhibition, the outward evidences appeared.

Brutality by adults and older children toward smaller ones is a very real fact and accounts for a certain number of cases of timid children. This point must be made. And the acts can come from many sources; the fact that an adult holds an important position in the community,

for instance, does not guarantee that he does not act brutally toward his or other children.

CHILDREN'S FEARS

The patients in Cases 8 and 9 are afraid because they have experienced real suffering from a hostile environment. Many children, however, show exactly the same symptoms without any evidence of having been subjected to fear-producing situations. I have said earlier that children as a rule seem more timorous than adults, a fact that has been the subject of several investigations, of which that of Jersild *et al.*¹ is best worth quoting.

The investigators examined 400 children (25 boys and 25 girls of each age group from five to twelve years, inclusive) for the presence of fears. They considered that a child showed fear when he admitted he felt afraid or when he cringed, retreated, withdrew, cried, trembled, protested, appealed for help, cowered, clung to his parents, or showed rapt or frightened attention in a particular situation. Of these 400, only 19 denied fears. Fear of the occult, of magic, giants and ogres, corpses, witches, and mystery and ghost stories were admitted most frequently; 27.1 percent indicated it as their greatest fear, and 19.2 percent that they had such a fear. Fear of animals was admitted by 17.8 percent, of strangers and being alone by 14.1 percent, of personal bodily injury by 9.6 percent, of nightmares and night apparitions by 8.8 percent, of bad people, robbers, kidnapers, etc., by 7.3 percent and of unusual gestures and noises by 6.8 percent. Eleven- and twelve-year-olds admitted more fear of the occult, of the dark, of strange and unfamiliar places and persons, of being alone, of strange noises, lights, shadows, of deformed and mutilated people, of nightmares and night apparitions than did the five- or six-year-olds (20.2 percent of the older to 11.1 percent of the younger). The older children also admitted more fears of being scolded or embarrassed or of not doing the right thing (4 percent of the older to 0 percent of the younger) and of startling events or noises (3 percent of the older to 1 percent of the younger). Five- and six-year-olds admitted more fear of animals (27.3 percent as compared with 11.1 percent of the twelve-year-olds), of bad people (12.1 percent as compared with 5.1 percent of the twelve-year-olds), and of having no fear (8.1 percent as compared with 4 percent of the twelve-year-olds).

¹ Arthur T. Jersild, Frances V. Markety, and Catherine L. Jersild: *Children's Fears, Dreams, Wishes, Daydreams, Likes, Dislikes, Pleasant and Unpleasant Memories*, Columbia University Press, New York, 1933.

Boys admitted more fear of personal bodily injury (12.1 percent of boys to 7 percent of girls) and denied having fear (6.5 percent of boys to 3 percent of girls). Girls admitted more fear of the dark, of solitude, of strange sights and noises than boys (17.1 percent of the former to 11.1 percent of the latter). Children with low I.Q.'s (i.e., I.Q.'s between 80 and 90) admitted more fear of bad people than those with I.Q.'s over 120 (12.5 percent of the former to 3.9 percent of the latter), and more children with I.Q.'s over 120 admitted fear of bodily injury (9.5 percent to 6.3 percent), of nightmares and night apparitions (11 percent to 8.3 percent), and illnesses and death of relatives (3.17 percent to 0 percent) than the children with I.Q.'s between 80 and 90.

In this study the authors were struck by the fact that the children were more inclined to fear things that were not likely to happen to them than things that were likely to; this was more frequently the case with the younger than with the older children.

Thus the majority of the fears admitted by the children were expressions of a feeling of anxiety rather than of fear. Anyone who has discussed a child's "fear" with him will reach the same conclusion. The child who has a great fear of kidnapers, for instance, is not usually the child of wealthy parents, where kidnaping is a possibility, but more often comes of poor parents. Of course it should be pointed out, as the authors do, that 55 of the children reported that other older children or adults had frightened them deliberately. However, this does not disprove the concept that the majority of children's fears are anxieties rather than realistic fears of true dangers.

In a later study of fears between the ages of three and six, Jersild² found that six-year-olds showed fewer fears than three-year-olds (three-year-olds showed 5.5 percent; four-year-olds, 6.3 percent; five-year-olds, 4.3 percent; and six-year-olds 3.2 percent fears). The younger children showed a great number of fears of strange objects, persons, situations, noises, and sudden and unexpected visual phenomena. The older children showed a decrease in the number of fears of strange events and animals but an increase in the number of fears of the occult, the dark, being alone, accidents and injuries, bad people, the loss or death of relatives, medical treatment, high places, ridicule and personal failure, and dying or ill health. This indicates that the fears of the three-year-olds were more often reality fears, while the six-year-olds showed more anxiety reactions.

² Arthur T. Jersild and Frances B. Holmes: "Some Factors in the Development of Children's Fears," *Journal of Experimental Education*, 4:133, 1935.

The children in these studies are not young enough to indicate whether the primary reaction in the human being is one of fear or of anxiety. Bernfeld³ makes the statement that infants have no fear but only anxiety, and cites as an illustration that when an infant is awakened it shows a contraction of the body, quivering of the limbs, and muscular action resembling a slight convulsion—the motor expression of anxiety. The younger the child is, the stronger is the expression of anxiety. Under three months of age the infant shows anxiety reactions when his instinctual needs are aroused and he wishes them appeased or when a familiar and loved object is changed. It is only as sensory perception develops that the child comes to associate an internal, uncomfortable feeling of anxiety with external phenomena. This association and the frequent warnings he receives from his parents as to the dangerousness of environmental situations and objects cause him to associate the inner feeling of discomfort with outside objects, and through this association he develops fear.

FEAR AND ANXIETY

What is the difference between fear and anxiety? Rado⁴ defines fear as a state of alertness to danger, of an anticipation of pain from impending injury characterized by an intellectual content, a specific feeling tone, and an absence of peripheral motor manifestations. In contrast, anxiety is characterized by no intellectual content but a specific feeling tone and peripheral motor disturbance, among which the most striking is a sudden and transitory impairment of breathing. These peripheral motor disturbances are well known and Kerr *et al.*⁵ have traced their physiology. Any overstimulation of the central nervous system results in the spilling over of impulses into the autonomic nervous system as follows:

1. Direct stimulation of the sympathetic nervous system produces rapid heart rate, increase in blood pressure, cardiospasm and pylorospasm; of the parasympathetic, relaxation of the superficial vessels and spasm of the colon.

2. Any such overstimulation produces hyperadrenemia.

³ Siegfried Bernfeld: *The Psychology of the Infant*, Brentano's, New York, 1929.

⁴ Sandor Rado: "Development in the Psychoanalytic Conception and Treatment of the Neuroses," *Psychoanalytic Quarterly*, 8:427, 1939.

⁵ William J. Kerr, Paul A. Glick, Mayo H. Soley, and Nathan W. Shock: "The Treatment of Anxiety States," *Journal of the American Medical Association*, 113:637, 1939.

3. The rapid breathing produced by sympathetic stimulation also causes alkalosis and its consequent symptoms.

These physical changes produce disturbances of physiology such as headache, nausea, vomiting, diarrhea, urgency and frequency, tremors and the awareness of the rapid beating of the heart. They are accompanied by a specific feeling tone—a state of uncomfortable apprehension. The whole syndrome is a reflex reaction to an overstimulation of the central nervous system.

What is the purpose of this syndrome? Like pain, anxiety is an emergency device to warn the ego that it should take measures to protect itself against some force that will harm it. In the infant, the reflex warns the infant's ego that it must try to do something to make itself more comfortable. Since the infant's ego is so undeveloped that it cannot produce discriminatory reactions, its reaction is the total one—general restlessness and movements—described by Bernfeld.

As the child grows, the ego develops a recognition of external objects and situations, the ego being that part of the mind that learns about and represents the external. Hence the child's ego causes him to be more afraid of the external world than of himself. He looks outside himself for the source of his fears and for relief from them. To this are added the warnings of the parents about the dangerousness of external objects and situations. All of this causes the child to tend to be more aware of external dangers than of internal ones. Therefore the child comes to feel that all the dangers associated with anxiety feelings are external; i.e., he projects the cause of the anxiety. This is the reason for the more frequent fears of real objects among three- and four-year-olds. As the child continues to grow, his ego perceptions cause him to realize that he often feels anxious when there is no ascertainable external danger. The mechanism involved is as follows: He has repressed from his consciousness the knowledge that when a small child he feared punishment by his parents for his acts. He came to fear any impulses toward those forbidden acts, believing that awareness of the impulses itself would lead to their performance; furthermore, he believed his parents would know even if he had the impulses only. Thus the source of his anxiety is unknown to him, and he postulates that the anxiety feeling must be due to external objects whose presence is not perceived by his senses. This accounts for the greater fear of the occult shown by five- and six-year-olds. Anxiety and fear, therefore, have the purpose of warning the individual that he is in danger, and so force his ego to mobilize defense measures. In early childhood, sense perceptions indicating that the child

is in real danger evoke the anxiety reflex, and the immature ego takes the defense measures of peripheral motor manifestations—measures that are a total inco-ordinate response and cannot ward off the danger, but that are all the child has at his disposal because of his immaturity. Later, as his intellect develops, its functions replace the former inco-ordinate motor reactions and the anxiety reflex becomes transformed into a fear reflex—a much more efficient protective measure but one which, as has been seen, tends to convince the ego that the danger is an external one. As Freud⁶ said, "It is quite an advance in self-protection when the possibility of a dangerous situation in which the individual would be helpless can be foreseen and he can be warned of its approach by a mild reminder; i.e., by a feeling of apprehension of what will happen to him if he persists in the direction he is going."

The more a real external danger threatens the ego, the more efficient as a protective measure is the fear reflex. The more the danger lies within the organism, the more the reflex has the nature of anxiety. It is possible, then, to divide children's fears into two groups: (1) fears of real dangers—real either in the sense that they do threaten the child's existence (the fear of being placed in charge of an adult who is really cruel to the child) or in the sense that the child really believes that his existence is threatened (the fear of being placed in charge of a strange adult whom the child does not know and who, he postulates, will be cruel because of the lack of familiarity). To these situations the child has a fear response, a justifiable one. (2) Fears of imaginary dangers—either purely imaginary ones or objects and situations of whose dangerousness the child has heard. He responds by an anxiety reflex that is not justifiable objectively; this condition is known as an anxiety state.

Clinically, these states of anxiety in childhood may be classified as follows:

- I. Acute attacks
 - A. Diurnal
 - B. Nocturnal
- II. State of continual apprehension
- III. Anxiety hysteria (phobias)
 - A. Of real persons
 - B. Of real things
 - C. Of imaginary persons or things

Class III, anxiety hysteria, will be discussed in the next chapter.

⁶ Sigmund Freud: *The Problem of Anxiety*, W. W. Norton & Co., Inc., New York, 1936.

I: A—ACUTE DIURNAL ANXIETY ATTACKS

CASE 10. A girl of eleven is brought for treatment because one evening, two weeks ago, she suddenly began to scream and cry and seemed very frightened and unhappy. She did not want to do anything, trembled, clung weeping to her mother, and would not be separated from her. At bedtime her clinging, crying, and screaming became worse, and although her mother remained in the room with her, she slept fitfully. She seemed a little quieter next morning but had no appetite and refused to go to school. As the day wore on, her attack recommenced. From this time until brought for treatment, she had several attacks each day, their violence increasing. She slept more and more poorly, and this, combined with the lack of appetite, caused her to lose weight. She said she was afraid she had made a mistake in the treatment of her younger brother. Since he did not seem to be learning much in the first grade, she had consulted his teacher and had advised that he be put in a special class. (This was done, it turned out, not because the patient had asked for it but because the teacher felt such placement was necessary.) She was sure he was not learning anything in the special class and felt that her attacks would cease if he were put back in the regular grade. During the acute attack there were many objective symptoms. There was an inhibition of physiological processes—she slept and ate poorly. She had feelings of nausea and abdominal pains, sensations of choking, alternating sensations of heat and cold, rapid breathing, palpitations of the heart, and trembling of the hands and feet and of the whole body. The tremor often became generalized motor restlessness—she could not be still a second. There was much screaming and weeping.

Such symptoms are found in all children with acute anxiety attacks. If the attack occurs when the child is away from home, he runs home as fast as he can and clings to one or the other of his parents or hides behind a piece of furniture or under the bed, from which place he cannot be removed except by the use of force. As the attack becomes worse, the child may stamp, throw objects, bang doors, pound on the floor with his hands or head, or beat his body. Sensory hallucinations may occur. (In my experience, they are always olfactory. The child detects an odor that is frightening to him.) At the height of the attack, the child seems completely overwhelmed by his feelings and pays no attention to what is said or done for him, except to become irritated by the attempts.

Subjectively, the child feels frightened. In some cases, this is the only feeling present. In others, as in Case 10, the feeling of fear is combined with a feeling of sorrow and remorse, which in some cases is much more marked than the fear. In still other cases, the child has a feeling of unreality—he does not know where he is or who he is. Associated with these feelings are frightening ideas. The child thinks he is dying, that he has been poisoned, that he is going crazy, that he will kill himself, that he will never be able to live and feel naturally again, or that he has committed a serious crime which he now regrets.

The attacks appear to begin suddenly, but on careful investigation it is usually found that the child was anxious and apprehensive for several days preceding the outburst, which can last from a few minutes to several hours. There may be only one attack, or they may be repeated. The severity varies in degree.

Similar acute anxiety attacks occur in adults. In my experience, children show more motor agitation than do adults, who are more inclined to be afraid that they are going insane or to complain of difficulties in thinking. Physiological disturbances are about equally common in children and adults.

During the attack the child feels he is in danger. The girl in Case 10 felt she had interfered with her brother's school progress and feared punishment. In reality, she had not been responsible for his having been put in a special class, but even if she had been partly so, no punishment could have followed, since it was the best place for him. She was in no objective danger even of falling under her parents' disfavor. She was suffering from remorse. Remorse, like guilt, is the punishment the superego⁷ inflicts on the ego when the former perceives that the ego has accepted or is about to accept an instinctual impulse that is un-

⁷ At this point I want to make clear my opinion as to the stages of the development of the superego and their chronological occurrence. There is little evidence for the presence of a superego before the age of two. Before this age there has occurred the repression into the unconscious of the desires and fantasies of the oral period. The child between one and two may show signs of dislike and distaste for certain objects, actions, and ideas. These indicate that there is a repressing force that warns the ego by these feelings to keep certain oral desires and fantasies unconscious. This is the first film, so to speak, of the superego. Between the ages of two and five there are many evidences of the presence of a preliminary superego which has developed as the result of toilet and other training experiences. During this period the child shows evidences of a feeling of guilt. Part of this feeling of guilt is fear of the parents' antagonism to the expression of

In other cases the child does not feel guilty or remorseful but simply feels he is in danger. Actually he cannot tell you the nature of the danger or the reason for it, because he does not know it consciously. He may state that he fears he will be harmed by some specific object or in some specific situation. Usually these objects and situations are not harmful, or if they are he is not likely to be exposed to them.

What is the nature of the unknown danger? It is not external, although the child would like to think so, but arises within the child himself—or, more specifically, the child's instinctual desires. The child may feel that his own instinctual desires are dangerous for several reasons. Freud⁸ points out one reason when he states that the danger that threatens the ego lies in the fact that it may be overwhelmed by the strength of the individual's instinctual desires. An example of this is found when a person is shut up without food and begins to starve to death. Eventually his hunger will become so great that he may be tempted to eat his own body. Thus his unsatisfied hunger would really overwhelm and destroy him. Instinctual desires, whether they be self-preserved (as in the example I have just given), erotic, or aggressive, demand constant gratification if the individual is to be tensionless. An increase in instinctual urges means an increased excitation which is painful unless relieved. This relief can come only through his rela-

On these grounds I believe that my concept of the presence of some kind of superego in children as early as between two and five is valid.

⁸ Freud, *op. cit.*

tionship with some object outside of himself. Freud⁹ originally thought that the instinctual desire, when it was not gratified, produced so much unpleasant tension that it had to be repressed—hence the feeling of anxiety. This appears to occur in the anxiety neurosis. A patient, for instance, suffering from physical symptoms and psychic feeling of anxiety due to the sudden termination of what had been an active sexual life (one in which there has been regular and satisfactory gratification of the sexual desires) will find that his symptoms are immediately removed when he is able to begin an active sexual life again. Adolescents who have been masturbating and who suddenly stop frequently show this picture.

Later Freud revised his concept of anxiety. He came to regard the feeling of anxiety as a signal occurring in the ego that some instinctual wish desired gratification, which might be dangerous. In the process of development there is a stage when an instinctual need is valid and conscious to the child. The desire to suck, for instance, is an expression of a sexual but pregenital desire to get physical pleasure through the use of the mouth and is valid and conscious during the very early part of life. As the child develops, this early form of expression has to be repressed into the unconscious and another form of behavior developed that will gratify his sexual needs more adequately. His biological drives and the pressure from his environment force him to attempt to develop a new method of obtaining sexual gratification, and he comes to regard consciously his desire to get sexual pleasure through sucking with a feeling of revulsion. But during the period when he has not yet found the new method adequately gratifying, he will seek gratification in the old way. Since the instinctual desire demands gratification and he has not yet found a satisfactory method of gratifying it, he feels himself in danger from the ungratified desire. He has a feeling of anxiety.

The child represses the original method of gratification because it represents an outworn stage of development. Often, too, he feels, and perhaps rightly, that he has had to repress it because of his parents. He feels that they may show their displeasure by rejecting him (fear of desertion and loss of love) or by punishment (fear of castration). If rejected, he would have no one to gratify his desires. The very young child depends on his mother for comfort, pleasure, and relief from discomfort and unpleasurable feelings. He comes to associate her presence with relief of tension and her absence with tension. On the other hand, punishment by mutilation would mean that the child would lose the

⁹ *Ibid.*

part of his body through which his desires can be gratified. In either situation he would be helpless and in danger of being overwhelmed by his own desires.

The child's fears of thus incurring his parents' displeasure pass through three stages. In the infant there is fear of desertion and loss of love; i.e., anxiety appears as a reaction to missing the loved and needed person. This is seen in the anxiety small children feel when they are left alone in the dark and when the familiar mother is replaced by a stranger.¹⁰ In the phallic stage there is fear of castration. In the latency period there is fear of social disapproval and of the reproach of conscience which in the unconscious is equivalent to death, castration, and desertion.

When the child's ego unconsciously perceives that an instinctual desire which he feels is unacceptable is demanding gratification, he becomes frightened lest one of these forms of punishment befall him. He becomes conscious of a feeling of anxiety, and because he unconsciously anticipates that the punishment will come from his parents, he consciously feels in danger from some external object or situation. Anxiety, then, is a warning to the ego that an instinctual desire is not being gratified or that it cannot be gratified because it is unacceptable. The warning signal of anxiety calls into play the fundamental pleasure-pain mechanism which forces the ego to do something about gratifying the instinctual need. The anxiety is also an attenuated living out by the child's ego of what he believes he may experience in an immensely greater degree if he does gratify his instinctual desires in a way unacceptable to his parents or to his conscience. It originates in the ego, because the id has no organization and is unable to judge what is or is not a situation of danger.

Much of early childhood is spent in the struggle to bring the instinctual impulses under the control of the ego through repression, redirection, etc., and often the course of the struggle goes one way and another, with the instinctual impulses victorious at one point and the ego defenses at another, so that the life of the young child becomes a succession of mild anxiety attacks. It is not until the latency period is established that any degree of stability and calm is attained, although here

¹⁰ Freud was not certain whether all the anxieties of small children could be explained on the basis of this discussion. He advanced the opinion that perhaps the fear of the dark, of animals, and of thunderstorms might be the atrophied remnants of innate preparedness against reality dangers which has been inherited unconsciously from our remote ancestors.

again the degree of stability is relative. Early adolescence shows a similar struggle, but here the evidences of the conflict are usually more violent and cannot be called mild anxiety attacks. Langford¹¹ found that the majority of his cases of anxiety attacks occurred in pubescence. Although in the cases he reported the patients were mostly girls, adolescent boys have just as severe and frequent anxiety attacks. The severity is due to the fact that the sexual drives are increased suddenly and greatly by the increased activity of the sexual glands. The defense mechanisms and the cultural prohibitions are directed against the sexual drives, but the adolescent feels that these defenses are relatively weak against the power of his instincts and so tends to feel frightened as he becomes aware of their presence. His anxiety attacks, therefore, tend to be severe, and often he flees from the pain of the anxiety feeling and from the power of his own instincts by developing defense mechanisms which produce what seem to be very severe neurotic and often psychotic reactions. In examining an apparently seriously disturbed adolescent patient, it is often difficult to determine whether the patient has a malignant neurosis or psychosis or whether the apparent severity of his symptoms is due largely to his adolescent development, in which case the symptoms will be greatly ameliorated as he grows older.)

(It is, therefore, to be expected that children would be more timorous—i.e., have more frequent mild anxiety attacks—than adults. The timorousness is due not only to his being small and weak but also to the fact that he feels his instinctual desires to be so strong and overwhelming as to render him helpless. His ego is weak, not only in regard to the world but also in regard to the ability to express and control his needs.)

(The instinctual desires which the child fears lest he cannot gratify them or lest he suffer loss of love, castration, or death are either the component sexual desires of the prephallic stage, the aggressive urges in the ambivalent reaction to the parent of the same sex (in the phallic stage), or the sexual urges toward the parent of the opposite sex. If they are the component sexual desires of the prephallic stage, the child will fear loss of love and desertion; if the aggressive or sexual desires of the phallic stage, the child will fear castration. Because of these fears the ego has repressed from consciousness, or in the young child is engaged in repressing, some part or all of their manifestations. Every

¹¹ William S. Langford: "Anxiety Attacks in Children," *American Journal of Orthopsychiatry*, 7:210, 1937.

time these repressed desires awaken and demand gratification, their presence is felt by the conscious part of the ego as a feeling of anxiety. As noted earlier, in the very young such feelings of anxiety are frequent, since the child's ego is weak and has not been able to find enough socially acceptable or physically possible outlets for the inner needs and consequently is in danger of being overwhelmed by their force. If the child lives in an environment that is not too restrictive, he will eventually be able to develop a state of equilibrium and the frequency of the anxiety attacks diminishes, although they will return to some degree during the period of adolescence, when there is a resurgence of inner needs, particularly sexual ones, as a result of physical development.)

When adult patients describe anxiety feelings, they usually describe them as a feeling that now frightens them but that at one time they felt as a thrill.

CASE II. A man complained of a great deal of giddiness and dreaded that he might fall down, faint, collapse, or die. So great was his dread that he was afraid to go on the street unaccompanied. In analysis it was learned that during childhood he often whirled round and round until he became giddy and that during the whirling he experienced a pleasurable sensation in the genitals. He also had a similar thrill when riding in a roller coaster. As an adult, without knowing why, he began to feel frightened whenever he rode in a fast-moving vehicle. In the childhood situation the rapid movement, besides producing the disturbance of equilibrium, also produced a sexual reaction. In the adult, similar movements of a lesser degree produced the disturbances of equilibrium plus a feeling of anxiety. The sexual thrill had been repressed and appeared now in the increase in sensations of equilibration and in the feeling of anxiety. This feeling was a warning to the patient's ego that an instinctual urge was awakening and that he should do something about its gratification. The recognition of the sexual sensation had to be repressed because he was brought up very strictly in regard to sexual matters and had been so severely threatened with castration for overt sexual behavior that he still unconsciously remained afraid of castration if he allowed himself to experience a sexual thrill.

A child with a hysterical character will dread an external object or situation. On the other hand, the obsessional child will regard instinctual desires as a rebellion against his parents or his conscience. He feels guilty when he desires to rebel against them and so feels guilty about

his instinctual desires. Like the girl in Case 10, he shows anxiety but says he feels guilt or remorse.

THE INCITING CAUSES OF AN ANXIETY STATE

(Severe anxiety attacks always have an inciting cause.) A careful study reveals that something was going wrong with the child's development before the attack began. I am loath to mention this fact, because psychiatrists who are not psychoanalytically oriented place too much emphasis on the inciting cause, particularly in the study and treatment of anxiety attacks in adults and adolescents. It is true that some change in the personal relationships of the patient has often been the inciting cause. In one case the mother had returned from the hospital; in another the child had been placed in a foster home; in another the boy's friends were all on vacation and he had no one to play with; in another the girl's father lived in a different state and had returned home for a visit; in another the boy's father had gone on a trip; and so on. In adult cases an engagement, a new job, or the severance—actual or contemplated—of a sexual relationship, more often a homosexual one, were the inciting factors.

Changes in interpersonal relationships in any human being produce a disturbance in the equilibrium of the entire psychic forces, and while the disturbance in equilibrium continues, the individual feels anxious. This is a well known fact in analytic work; if the patient or analyst goes on a vacation the patient may regard the change in his usual status as dangerous and become panicky. However, the degree of the disturbance and the amount of anxiety liberated, particularly in the adult and adolescent, depend on the degree of flexibility of the synthetic function of the ego. The adult and adolescent patients who are unable to tolerate a change in their present relationships and who regard such a change as a grave danger to their life and sanity have immature egos. Their reaction is exactly that of the young child who is suddenly separated from his parents and finds himself among strangers and therefore in danger. Similarly my adult patients who come for treatment because of an acute anxiety attack all have extremely immature personalities and feel incapable of any independent action. The inciting cause is one that produces a fear of being left alone, cut off from the accustomed relationships to other people. In all the cases that I have studied, the dreams and the intrapsychic material show that the change in circumstances produces an increase in the instinctual impulses either by producing a situation whereby the instinctual feelings come closer

to consciousness—as in a little girl whose father had returned home for a brief visit—or by curtailing the possibility of indulging in erotic satisfaction, as when a boy was separated from an indulgent mother. Not only are the erotic drives stimulated by a change in interpersonal relationships, but the aggressive impulses are stimulated if it seems to the patient that the gratification of the erotic desires is to be frustrated. The aggressive impulses are directed against rivals who may interfere in obtaining erotic gratification—the mother and brother in the case of the girl whose father returned home—or who actually do interfere—the person who separated him from his mother in the case of the boy. These hostile, aggressive impulses are very strong and are accompanied by ideas of injuring or killing the rival. Their sudden stimulation makes the individual feel that he is losing all control—i.e., that he will go berserk—and he is left with the problem as to who will suffer from the impulse—himself (feeling he must commit suicide) or the rival (feeling he must commit murder). He feels that he is in danger of a violent attack of temper, in which case he has a marked feeling of fear. If his training has taught him that violent temper outbursts are bad or if he is very fond of the rival, the presence of the murderous impulse is felt more as sorrow, guilt, and remorse. The danger that produces the fear in the acute anxiety attack is therefore an internal one. The inciting circumstance is important only in that it has stirred up a conflict of marked feelings which the patient does not know how to solve.

(This is the only importance that the inciting circumstance has in the anxiety attacks of adults, adolescents, and children at the end of the latency period. An attempt to cure the attack by the undoing of the inciting cause will be valueless because it will not help the ego toward a solution of the intrapsychic conflicts.)

(The inciting cause, however, is of greater importance during the prelatent period and the early part of the latent period. Then it is no longer an inciting cause but a traumatic event which may have far-reaching effects on the developing personality, particularly on the capacity of the ego to develop its functions adequately. It would seem desirable, therefore, to spare the little child as much as possible from any serious change in his interpersonal relationships.)

I have seen only two cases where the attack followed closely on an actual frightening experience, and in each case the child had just seen a movie. Let me say that neither movies, radio stories, nor anything the child reads or hears can in itself produce an anxiety attack. The story does nothing more than stir up an internal conflict already present.)

and the attempt to find a solution to the conflict results in the attack. Children appear to react to real frightening experiences in other ways than an acute anxiety attack. If the child is badly frightened by a real experience, he tends to run to his parents for help and to tell them what has happened. Since the parents know the cause and can appreciate why the child is frightened, they deal with the situation themselves and do not take the child to a physician. If, on the other hand, the child has been frightened by a real experience and for various reasons does not tell his parents, he is more likely to develop nocturnal anxiety attacks (frightening dreams), to become generally apprehensive, or to alter his activities to avoid a recurrence of the fright. Of course, in every case careful inquiry should be made to ascertain whether a child has been subjected to a real frightening experience.

I do not know why some children react to changes in intrapsychic forces produced by a change in their relationships with other people by an acute anxiety attack while others react with other types of symptoms. In the case of adults, it has been pointed out that the patient already had an ego too weak and immature to deal with a sudden exacerbation of instinctual energy. (Since the childish ego is naturally immature, it might be expected that therefore all increases of instinctual tension would result in acute anxiety attacks. This is not so, for such acute attacks are not very common—only about 12 per cent of all children are referred for them.

In endeavoring to answer this question, I reviewed, in the cases that were referred for acute anxiety attacks, the pertinent historical material (parental attitudes and traumatic experiences, separations, illnesses, and injuries), and was not able to find any specific etiological factors that could not be duplicated in children who had no history of an acute anxiety attack, although they had other symptoms. Even the case that showed the most acute and prolonged attack threw no light on any specific factor.)

CASE 12. A boy of twelve had a severe, sudden, and prolonged anxiety attack during which he spent most of the time under the bed; he also had olfactory hallucinations. The inciting cause was the return of his mother from the hospital. She had been ill and hospitalized many times. His father was an inefficient person who also had been in the hospital. There were two younger children in the family. The patient himself had been ill many times and had been hospitalized once. His personality before the attack had shown many evidences of insecurity—excessive desire for possessions, excessive appetite, sullen reaction to

necessary deprivations, and a need to make himself important through the telling of fanciful stories of his own prowess. However, none of these factors are specific.

THE PROGNOSIS OF ACUTE ANXIETY ATTACKS

What happens to children who have acute anxiety attacks? The attacks seem to be self-limited. They may continue unaltered for several weeks, but eventually they subside. This is probably the reason why these cases are seen more often by the pediatrician or general practitioner than by the psychiatrist. The child is brought for an acute attack and is given sedatives, and after a few days the attack subsides and both the parents and the doctor are satisfied that the child has regained his health. This self-limitation of the attack produces two difficulties for the psychiatrist. He cannot be certain whether his treatment has resulted in the cure unless he makes sure that the entire conflict has been satisfactorily solved, which is often difficult to do because after the acute symptoms have subsided both the patient and his parents, particularly the latter, see no need for further treatment. As the acute attack subsides, all of these children have been able to solve in some fashion the conflict that caused the attack. A few, probably, are able to find without any treatment a solution that will not interfere with their further development; but in every case the severity of the attack indicates that the conflict is a serious one and makes one feel that an adequate spontaneous solution cannot be very common. (These attacks differ from the usual mild, short-lived attacks of early childhood which are produced by developmental readjustments of intrapsychic tensions and can be solved in an adequate manner.) The usual result of an acute anxiety attack is that the child represses some element of the conflict with temporary relief. This further repression occurs at the expense of malformations in the ego (character neuroses) or weakens the ego capacity so that a later neurosis is almost inevitable. In one untreated case that I was able to observe during the attack, the patient, several years after the attack had subsided, developed an anxiety hysteria with some schizoid symptoms. Several adults with marked neurotic manifestations gave a history of an untreated acute anxiety attack in childhood, and it was easy to observe that their adult neurosis actually began following the subsidence of the acute attack. It seems to me, therefore, that the prognosis for a continuation of normal development following an acute anxiety attack without treatment is very poor.)

The diagnosis of an acute anxiety attack is simple and is made on the

basis of personal observation of the child during the attack or of the parents' description of his behavior. However, it is usually not possible to predict what the outcome of a severe acute anxiety attack will be. As I have mentioned, the child may apparently become completely well spontaneously or he may later show any type of neurotic or psychotic illness. The earlier treatment is instituted, the better for the patient.)

THE TREATMENT OF ACUTE ANXIETY ATTACKS

(Treatment will be directed toward determining the intrapsychic conflicts that are causing the conscious feeling of anxiety. Since the conflicts are usually completely or partially unconscious, treatment will have to be by psychoanalysis or by psychotherapy that is psychoanalytically oriented. I believe very strongly that such cases should be treated *only* by a child analyst because of the possibility of malignant outcome. The time and money necessary for the psychoanalytic treatment of cases of acute anxiety attacks are perhaps better expended for this type of case than for some others I will discuss later.)

I: B—ACUTE NOCTURNAL ANXIETY ATTACKS

These are usually referred to as nightmares or night terrors.

CASE 13. A nine-year-old boy suffers from night terrors. After a day of ordinary activity he goes to bed and falls asleep rather promptly. Several hours later the parents are awakened by his screaming. On going to his room they find him either sitting up in bed or standing on the floor, his eyes open, screaming, crying, and shaking. If they approach him or speak to him, he becomes more frightened and tries to get away or strikes at them, acting all the time as if they were dangerous objects. After this behavior has continued for a variable period, from a few minutes to several hours, he quiets down and sinks into an exhausted sleep. On awakening he usually has no recollection of any disturbance during the night and often does not believe his parents' report of the attack. If he does awaken during the attack, he says he had a very frightening dream and may even describe it, but the next morning denies he has made such a statement or had such a dream. During the day he shows no unusual behavior or reactions, although he tends to be somewhat nervous and high-strung. These attacks occur about once or twice a week.

After treatment was instituted, it was learned that each attack was the result of a frightening dream. His first reports were that in the dream,

animals or persons were chasing him. Later he was able to be more definite as to the dream content. He reported one in which he felt that someone—he did not know who—was going to tear his arm off. This dream was typical of all the others he reported—in all either he or another person or an animal suffered or was about to suffer some bodily mutilation and he felt extremely frightened.

This case is a good example of a severe attack of night terrors, though the same degree of severity does not occur in all children. The child awakes screaming and reports that he has been frightened by a dream, usually of bodily mutilation. Although the behavior during the night terror in these milder cases is not as bizarre as in that of the boy, the feeling of fear is just as great. The child may not tell anyone that he has frightening dreams. Often he tries to avoid going to bed by dawdling or rebelling. The parents, not understanding that he is afraid to go to bed, become angry and treat him as a bad child. He may go to bed but demand that one of his parents stay with him, may produce many excuses in order not to stay in bed, and so on. Here again the parents often ignorantly regard him as naughty, not realizing that he behaves in these ways in order to escape the fear of his dreams.

PSYCHOPATHOLOGY OF NOCTURNAL ANXIETY STATES

The dream content furnishes a clue to the cause of the fear. In the dream, the child's psyche is concerned with the idea that he may be mutilated, and often in the dream or in the sleep talk he pleads that he be spared the injury. He behaves as though he really were afraid he was going to be punished by bodily mutilation. Now, what crime could a child commit that would call for such ferocious chastisement? A number of years ago Gardner¹² reported the underlying psychopathology, which is well illustrated by Case 14.

CASE 14. A boy of four and a half was referred because of severe attacks of night terrors that began about a year before his referral. The mother had caught him masturbating and because of her fear of criticism by family and neighbors she threatened him by saying that if he masturbated again she would cut his penis off. The boy stopped masturbating, and immediately began to have night terrors with the content of fear of bodily mutilation. The mother was persuaded that it would be wise to assure the boy that she had not meant what she said and that she would not injure him if he masturbated. As soon as he began to

¹² G. W. Gardner: "Night Terrors and the Mutilation Threat," *Psychoanalytic Review*, 19:182, 1932.

masturbate again the night terrors ceased. However, the mother was not able to tolerate the sight of the boy's masturbation and after several months threatened him again. Immediately he stopped masturbating and his night terrors recommenced. The night terrors were an attempt to solve a serious conflict. The child had the desire to masturbate, as do all children. He had been threatened that his penis or his hand would be cut off if he did. So he stopped his masturbation. But his desire to masturbate continued and troubled him constantly, particularly in his sleep. While he slept, the dream of punishment for his wish occurred, frightening him and waking him in order to stop consciously even the involuntary masturbation that might occur in sleep.

The enlightened reader will express wonder that in America there still are parents who disapprove strongly of the normal masturbation of childhood and who feel they must stop it at all costs. But the fact is that the old superstitions regarding masturbation still exist even among intelligent parents. Huschka¹³ found that over 50 per cent of a moderately large group of problem children in Chicago had actually been threatened by their parents with castration in trying to stop their masturbation.

In my opinion, night terrors are usually the result of such threats by parents or other adults in charge of the child. However, there are children who suffer from this disorder because they feel guilty about the fantasies in which they indulge during the act of masturbation. They *feel* they should be punished for their horrible thoughts as well as for the act. During sleep when the desire to masturbate tries to break through into consciousness, their ego warns them to refuse to permit it by pointing out the fate that should be theirs if they do. These masturbation fantasies will be discussed more fully in Chapter XI.

THE PROGNOSIS OF NOCTURNAL ANXIETY ATTACKS

Untreated, these night terrors persist for a long time and then gradually subside. The child may learn from some source outside the family that masturbation will not result in mutilation and therefore begin the act again in secret, and his normal development can continue without being too much injured. This is rare. The terrors usually subside because the child's development has been halted suddenly. The child, being deprived of an adequate outlet for sexual gratification, has resexualized some earlier form of sexual experience which he had given up—e.g., thumb sucking or anal interests—or has sexualized

¹³ Mabel Huschka: "The Incidence and Character of Masturbation Threats in a Group of Problem Children," *Psychoanalytic Quarterly*, 7:338, 1938.

some of his character traits. The latter causes his personality and behavior to become different from that of the average child of his age. Such an outcome is well illustrated by the following case.

CASE 15. A twelve-year-old girl is brought for treatment because of constant quarreling with and cruel destructive behavior toward her older brother that started when she was nine. Since the age of eight she had suffered from a nightmare in which she is in danger of death. During this period she got on well with her brother. The nightmare bothered her so much that she decided to stop it by will power. She did so, and immediately thereafter her behavior toward her brother changed. The nightmare itself began after a period of sex play with her brother had been stopped by her parents' threat that she would die if she continued. She suppressed her sexual attachment to her brother by the series of frightening dreams. When she stopped these she was in difficulty, for her sexual urges toward her brother were still present, though suppressed. She dared not express or gratify them openly, so she began to tease him and do things to make him angry. He would then attack her physically, wrestle with her, spank her, etc. This bodily contact gave her partial sexual gratification but gratification of a masochistic rather than of a phallic nature. Her sexual enjoyment of joyous genitality gave way to fear of temptation—the fear appearing in her dreams—and this in turn gave way to the character change that caused her to attack the object of temptation. These changes show a regression from the genital to the anal-sadistic stage.

In the adult cases that I have studied showing a history of untreated nocturnal anxiety attacks in childhood, the cessation of the night terrors was followed by regressive changes in the patients' personality development, as in the case just cited. These changes persisted into adult life, seriously interfering with any real adult sexual adjustment.

The psychopathology of night terrors indicates the method of treatment. The child will have to become conscious that he fears punishment by mutilation for his desires for instinctual gratification. When he becomes conscious of the two sides of the conflict—his desire for instinctual gratification and his fear of punishment by mutilation—he can be relieved of the fear.

II—STATE OF CONTINUAL APPREHENSION

CASE 16. A boy of eleven is referred because of "nervousness." He is continually apprehensive, although he tries to behave as if he were courageous. He is restless, bites his nails, and cannot bear to have his

clothes too tight. He suffers from enuresis, about which he appears indifferent. At times he laughs in a silly manner. He has temper attacks. He dissolves in tears at the least sign of criticism. He starts to quiver when scolded, although his parents are not oversevere. He seldom plays with other boys and expresses overt hatred of girls and dislike of his older sister. He dislikes all movies. He is overmodest. He has poor appetite. His school progress is not affected, although he said he was not ambitious. He suffers from frightening daydreams. When sitting on the toilet he has the frightening fantasy that robbers are breaking into the house. Often he dreams of dead men. At the age of six he had a nightmare in which he felt that the houses were closing in on him.

In this case there was no evidence of definite attacks of anxiety, either nocturnal or diurnal, but, rather, mild anxiety continuously throughout the whole twenty-four hours. The anxiety was attached to no definite object, expressing itself, rather, as a vague phobia of robbers and of having his clothes too tight. There was also an exaggerated fear of punishment, as if he expected to be terribly hurt for even the most trivial offense. He tried to conceal his fears by pretending to be courageous. Associated with the anxiety were marked restrictions on his activities. He did not play with other boys, he disliked movies, he was overmodest, and he was ambitionless. He did not feel toward girls as boys of his age usually do. Instead, he openly expressed his hatred of them and his dislike of his older sister. He had converted some of his anxiety into disturbances of physiological functions. He was restless, bit his nails, his appetite was poor, and he wet the bed.

The cases falling into this group serve as a connecting link between those who have acute anxiety attacks and those who have phobias, all revealing free anxiety with or without an object, inhibitions of activity, and some conversion symptoms, so that all of them can be diagnosed as anxiety hysteria.¹⁴ However, because they have a slightly different clinical picture from the cases of phobias, I prefer to catalogue them as anxiety states. Since this group is a connecting link, the symptoms will vary from attacks resembling acute anxiety attacks to conditions where the phobic element is more prominent.

TREATMENT

Under the various clinical types of anxiety states, I have discussed briefly their specific dynamics. In Chapter XVI, I will give a detailed

¹⁴ Sigmund Freud: *Collected Papers*, Hogarth Press, London, 1933, Vol. III, p. 257.

description of the various methods of treatment. These are applicable to the treatment of all the anxiety states. Here I wish to discuss some methods that are valuable in preventing the occurrence both of serious anxiety attacks and of anxiety hysteria.

Anxiety feelings are a necessity. The psychopathology of the anxiety reaction shows that it is impossible to prevent the occurrence of mild anxiety attacks in childhood. As long as the ego is weak because of immaturity, it will be unable to master the powerful inner instinctual urges and will have to endure the recurrent feeling of helplessness to which these impulses subject it. The more immature the ego is and the fewer skills the child has, the less able he is to solve the struggle between his powerful and conflicting instinctual urges and his environment and so come to a state of equilibrium. The younger the child, the more frequent and violent will be the anxiety feelings. The presence of such struggles is seen both in the timorousness of the small child and the fearfulness and anxiety attacks of the adolescent. Only with the beginning of adulthood has the ego developed to the point of being capable of dealing with the two opposing forces of external reality and the instinctual life. Mild anxiety attacks are therefore to be anticipated during the first two decades of life and signify that internal adjustments between the forces of the id, ego, and superego are taking place. These are most likely to occur at the points when shifts in libidinal organization are taking place; i.e., the change from oral to anal, from anal to phallic supremacy, from the Oedipus situation to the latency period, at adolescence, or during universal traumatic occurrences—the temporary absence of the parents, such as occurs when the child starts school. Let it be said that it would not be desirable to shield the child from all feelings of anxiety even if that were possible, for one phase of the development of ego maturity depends on the ability to recognize easily the beginnings of the anxiety feeling so that measures can be taken to give adequate expression and gratification to the instinctual needs. In fact, the more the individual remains unconscious of the presence of the anxiety feeling, the less capable he is in his daily life. There is a group of neurotics whose outstanding characteristic is the absence of any conscious anxiety reactions. The repression of the anxiety feeling into the unconscious causes them also to repress the needful fear reactions, and as a result they constantly place their lives in jeopardy as if they must deny the possibility of danger. With the repression of the anxiety and fear feelings into the unconscious, there is associated, of necessity, the repression of the instinctual needs so that the individual behaves as if he had no feelings.

How can a child be so managed as not to receive an extreme dosage of anxiety? During his development he should be allowed to experience some anxiety, but every effort should be made to see that the dosage at any one time should not be too large. The change from the oral to the anal-sadistic stages of libidinal development at the time of weaning should be made gradually. Supplementation with solid foods should be carried on along with breast feeding. The routines of the first year are necessary but should not be adhered to too rigidly. The process of toilet training should be gradual and control should be neither too suddenly, nor too harshly, nor too weakly demanded. Too early and too complete independence is not to be sought, nor should too long dependence be fostered. Each step in development requires a readjustment of ego skills, and this readjustment takes place gradually. A too sudden forcing of the readjustment causes the ego to be exposed to excessive amounts of stimulation, with which it is inadequate to deal and in the face of which it can feel only anxiety.

Excessive feelings of anxiety can be prevented by the elimination of situations that call forth unnecessary and excessive doses of anxiety. In his description of the case of Little Hans, Freud¹⁵ pointed out that before the attack began, Hans had been subjected to the attentions of a mother who fondled him a great deal, was overindulgent, and encouraged him to get into her bed. There must also have been evidence of the beginning breach between the parents that culminated in their separation, which Freud notes in his postscript, a circumstance that would call forth strong erotic feelings for her and that would increase his jealousy of his father. This would make the boy desire that the parents should separate in order that he might have the mother for himself and would make his wishes that the father would leave seem too close to reality, for he loved his father. The father was frequently absent, which circumstance would make the boy feel that his wish for the father's death might come true and thus result in his loss. Freud pointed out that the father's frequent absences from home laid the ground for the increase of the boy's wish for his death. Thus to his normal Oedipus conflict there were added the attendant circumstances of an overaffectionate mother, a father who was absent frequently, and a tense marital situation. In the discussion of the case, Freud pointed out that anxiety hysterics tend to develop in individuals who have a predisposition to this type of neurosis because the experiences of their

¹⁵ Sigmund Freud: "Analysis of a Phobia in a Five-Year-Old Boy," *Collected Papers*, Hogarth Press, London, 1933, Vol. III, p. 149.

life have given them greater conscious anxiety feelings. These experiences I described earlier as traumatic occurrences which produce excessive stimulation of instinctual urges through unnecessary frustrations or indulgences. Such excessive stimulation tends to make the ego feel helpless and so weaken its capacity for development. If at all possible, these traumatic occurrences should be excluded from a child's life.

The child's ego may be weakened in another way. A child learns to deal with his inner impulses and the fears he feels because of them through identification with the parents. If the parents are inconsistent, the child will identify with their inconsistency. Such an identification with an inconsistent parent means that the child's ego at times overcontrols the instinctual impulses and at others allows them free and direct expression without regard to the reality of the situation, just as the inconsistent parent overcontrols or indulges at the behest of his own fancy with little regard for reality. Parents should be consistent if they wish their child's development to proceed adequately.

I have stated earlier that many children complain that they have been deliberately made afraid of certain objects by adults or older children. This may come about in two ways. Either the adult or older child himself has phobias and through his reactions indicates that the object is one to fear, or the adult or older child deliberately tries to make the child afraid of an object or situation for a malicious purpose or because he feels it is proper to have such a fear. As the child learns to control the situation which causes the anxiety feeling by identifying with the adult or older child, he will also identify with that person's fears. The mother who constantly indicates to her daughter that men are dangerous persons or who deliberately turns her daughter against men can expect only that she will be afraid of men to the detriment of the possibility of a heterosexual adjustment. As far as possible, no child should be subjected to such conditions.

Excessive anxiety reactions can be prevented by the elimination of circumstances that cause an increase in the child's fears of his parents' reactions toward him—i.e., in the severity of the superego. The superego is formed through identification with the parental commands. If the parents are themselves oversevere toward certain of the child's instinctual urges, the child will take over the attitude, and the stirring of his instincts will be felt with a greater amount of anxiety feeling than would otherwise be the case. In the case of Little Hans, the boy had actually been threatened by his mother with castration if he touched his penis. This threat was not accepted until his investigation of the genitals of a

little girl, whereupon the threat of castration now appeared as a real possibility. He knew now that there were people in the world who did not have penises, i.e., who had lost them. Children arrive at the conclusion of a possibility of castration through such observations anyway but are not so impressed unless previously threatened by their parents. The particular way in which the instinct is expressed may be condemned by the parents as not desirable from the standpoint of the adult's culture, but it is the usual mode of expression for the child at his cultural level. Since it is an expression of an important inner urge, the parent's threat may not only stop the manifestation of the urge in its present form but may stop also all other expressions of the urge in adult life, even those that are culturally acceptable.

CASE 17. A boy was threatened by his mother with eternal punishment by God if he masturbated. He adopted her attitude, stopped his masturbation, and in adult life was afraid to have intercourse with his wife lest God punish him. The mother's threat had affected not only the manifestation of the sexual impulse to which she objected but the impulse itself and all its later adult manifestations.

On the one hand, too strict training—the forcible suppression of the need for instinctual gratification—damages the ego's capacity to find satisfactory ways of gratifying the instinctual needs and as a result, the presence of the instinctual desires will be felt by the ego as anxiety. On the other hand, if the child has been allowed constant and immediate gratification for all his instinctual desires, his ego never develops the ability to tolerate small amounts of anxiety. He never learns how to channel and redirect his inner needs so that they may obtain more acceptable and more realistic methods of gratification. As Waelder ¹⁶ says, "Too strict education damages the instincts; too liberal education results in damage to the ego."

Children should be allowed their natural modes of gratifying and expressing their instinctual urges, and such manifestations should not be halted by the parents through threats that utilize the major fears of childhood—desertion, loss of love, and castration. These threats cause a great fear of the impulse and the ego feels any stirring of the impulse as a feeling of severe anxiety. If a child is to develop without too severe attacks of anxiety, his life should be one in which circumstances do not excessively strengthen the power of his instinctual demands, do not weaken the ego's ability to deal with the usual strength of the urges, and

¹⁶ Robert Waelder: *Lectures on Ego Psychology*, Philadelphia Psychoanalytic Institute, 1939.

do not impose unnecessary restrictions on their expression and gratification. This is true for the child during the prelatent period, but even during the period of latency circumstances should be avoided that place too great a strain on the interaction of the instincts, the ego, and the superego, whose structure will by this time be nearing completion.

Excessive anxiety feelings may be prevented by intelligent dealing with the usual mild anxiety attacks. When a small child develops a mild phobia or other manifestation of an anxiety feeling, the usual treatment is to reassure the child that the object or situation is really not to be feared. This is a correct procedure because it strengthens the child's knowledge of reality; i.e., it strengthens his ego. It does not consider, however, the instinctual impulses that are responsible for the feeling of anxiety which is due to their not finding a means of gratification.)

CASE 18. An intelligent five-year-old girl rather suddenly developed a phobia of moths. The fear was so silly that it could have been apparent to the parents that the amount of fear displayed indicated that something else must be responsible for its presence. Reassurance by the parents had no effect on the fear except to make the child ashamed to talk about it. Study of the situation revealed that the phobia developed shortly after the mother became pregnant. The mother tried to keep her pregnancy a secret from the child but was not successful. The mother's pregnancy aroused a number of conflicting desires in the child:

1. She wished to have a child of her own.
2. She did not wish her mother to have a child because she was jealous of the mother and did not want her to have the special relationship with the father that the pregnancy indicated. She was afraid of her mother's anger if she expressed these feelings and also was afraid that if she were hostile to her mother she would lose her love.
3. She did not wish the mother to have another child because its coming would threaten her already precarious relationship with the mother, who really rejected her and favored her older sister.
4. She was curious as to why the mother kept the pregnancy a secret, as to how she had become pregnant, and as to what was going on inside her body. This curiosity was regarded by the mother as bad and so had to be kept secret.

Thus there were a series of conflicting urges—erotic desire for a child, jealous hatred of the mother because of her special relationship with the father, the wish to dispossess the mother of the child so that she would not have to share her love with the new baby, desire that the mother should not have something she did not have, and curiosity which was

denied gratification and which she felt could be satisfied only by actually boring within the mother's body and finding out for herself what was happening. All of these had to be suppressed lest they get her into trouble with her rigid, puritanical mother. Consequently she felt them as uncomfortable *inner* feelings. At about this time she seems to have heard that moths devour clothes and other *possessions* in *secret*. The idea of the moths served as a projection for her own instinctual urges. A mother who recognized that these feelings are natural would have dealt with the phobia by permitting a free discussion with the child of her pregnancy, allowing her to express freely and without condemnation her feelings about the pregnancy, informing her that she later would have a baby of her own, that the present would be a good time to learn how to look after a baby, and that a doll for which she could care as if it were a baby would be a desirable gratification of her wish to have a baby of her own. If the little girl had been given a doll and taught to care for it as if it were a baby, she would have learned much of value in handling a baby of her own when she grew up. If the mother had answered the child's questions about pregnancy, the child would have acquired useful knowledge. If she had allowed the child to express her feelings freely about the pregnancy, the child would have learned more about her real inner self. Through these procedures her ego would have been strengthened by the acquisition of new skills. It might have been desirable to reassure her that moths are not really dangerous, but I think the example clearly indicates that such reassurance is of minor importance compared with the need to deal with the turmoil in the child's mind. When parents and physicians are more aware of the real causes for anxiety feelings, they will deal with them by determining what present difficulty in the child's development has been encountered and by helping the child in an intelligent manner to learn to deal with his instinctual urges.

CHAPTER FIVE

ANXIETY HYSTERIA

ANXIETY HYSTERIA is a condition in which the patient has an unreasonable fear of some external object, the result of having repressed certain instinctual desires into the unconscious lest he be punished for having them. The fear of retaliation is repressed also. The whole complex is projected onto an external object, person or thing, which is feared lest it retaliate, as the patient feared the real object of his instinctual desires would do. In some cases, the knowledge that an external object is feared is repressed also, and the patient feels only free-floating, unorganized anxiety.

THE SYMPTOMS OF ANXIETY HYSTERIA

CASE 19. A boy of ten is referred for nervousness. One of his most outstanding symptoms is a fear of fire engines. On hearing one in the distance he shakes, covers his ears, cries, and runs to the house, venturing out only after he is sure it is entirely gone. The fear has been present for several years. Of course young children must learn to be cautious about fire engines, but the fear shown by this boy is excessive; i.e., he has a phobia. The feeling of fear in the phobia is really a feeling of anxiety, and he has projected the cause of the anxiety onto an external object—onto fires and fire engines.

Children with phobias show unreasonable or unnecessary fear of real persons, objects, and occurrences, the vast majority of fears shown by children in reality being phobias. When the phobia is of an object that is really dangerous—e.g., of lockjaw, death, dogs, cats, rats, horses, guns—

the degree of the fear notwithstanding, I believe the child is less ill than if the phobic object is an imaginary one.

CASE 20. A girl of eight is referred for nervousness. Her outstanding symptom is phobia of a horse. This horse, which is really a compound of horse and dinosaur, stands at night in the yard next door. It stretches its snakelike neck up and up until it can insert its flattened triangular head sideways into the window of the child's room and there remain motionless. The little girl cowers in bed, shaking with fear, too frightened to cry out, creeping farther and farther under the covers until she falls asleep curled in a knot in the middle of the bed with every part of her body well covered by the bedclothes. She is afraid to remain in her bedroom even during the day, going upstairs to bed trembling, with her heart pounding wildly and with panting breath. She tries to be brave and not let her parents know she is so frightened because she realizes that the object she fears would be imperceptible to them. Only in treatment and with great reluctance has she revealed to anyone the story of the dinosaur-horse. This girl has a much more serious intrapsychic conflict than the boy in Case 19. He is afraid of an object that really is dangerous; she of an object that has no real existence.

Almost any object, whether dangerous or not, perceived or seen in a picture or heard of or imagined, may constitute a phobic object for a child. I have seen children who had phobias of butterflies, bogey men, policemen, burglars, kidnapers, balloons, the dark, bicycles, the seashore, imagined objects in the throat, vacuums, closed doors, bears (when the child knew perfectly well there were no bears within fifty miles), spiders, caterpillars, pictures in fairy tales or religious books, tall buildings, having too tight clothing, a deformity of the thenar eminence of the hand although no such deformity was present, and others too numerous to mention. The children become panic-stricken when they see or think of the object.

Children with phobias suffer from anxiety hysteria. What are the reasons for the phobia?

THE PSYCHOPATHOLOGY OF ANXIETY HYSTERIA

CASE 21. A six-year-old boy is referred because he refuses to go to school. When in school he is stubborn and does not seem to learn. His mother reports that he has enuresis, does not get along well with the father, and complains of abdominal pain about three times a year, the attacks lasting only a few minutes and always occurring at night.

His refusal to attend school started about a month before when he refused to enter the building when the bell rang. No amount of persuasion was effective, so the janitor took him in by force and made him sit in the basement for punishment. Each time the patient wanted to go to the bathroom, the janitor made him stay on the bench. He was then taken upstairs and whipped by the principal in front of the other children. The patient did not tell the mother about the episode, but several days later other mothers reported it to her. Shortly after, he came home from school on five successive occasions before ten o'clock, complaining that he was sick at his stomach. Later the school doctor brought him home and told the mother that he was not acting normally: in the principal's office that morning he crawled under the desk and refused to come out. The principal threatened to cage him like an animal. Finally the janitor got him out. The boy told his mother that he had gone under the table because he was afraid the principal would whip him again. This was also his reason for not wanting to tell her about the previous whipping episode. The principal said she had never whipped him, although she did have the authority to do so; however, she did threaten him in front of the other children in his class. She said that on both occasions he displayed a violent temper and was so angry that she called two men to hold him and take him upstairs. The patient got along well in kindergarten, his school difficulty starting on entering the first grade the previous fall.

The enuresis occurred both during the day and at night and had always been present. Occasionally he came home from school saying he was embarrassed because he had wet himself. He had been treated for this symptom by many doctors but without success.

The Family Constellation. The family consisted of the father, mother, patient, and a three-year-old brother. Only for the last year and a half had the four lived together in one place. Before that, they had been separated, moving frequently and often living with relatives. This fall, when the mother's sister and her seventeen-month-old baby came to live with them temporarily, the patient had an acute attack of anxiety. When his father was away the patient said he was very fond of him; but when his father was at home, the boy would never let him do anything for him; instead, he insisted on his mother doing it. He showed a similar behavior toward his uncle. Several weeks ago the patient and his family visited the uncle. The uncle, not knowing the patient did not like wine, insisted that he take it. The mother attempted to stop the uncle's insistence but could not before patient ran out of the living

room crying and hid under the dining-room table. The more the uncle tried to stop his crying and bring him out, the more the patient cried and the farther he crawled under the table. When the uncle visited the house, the patient used to run constantly to the back window and look out, saying he had heard a noise in the yard.

The father had often been away for long periods, and he was inclined to be overstrict with the boy. He objected strongly to the mother's attitude toward her son, which he considered to be a babying one. The mother was apparently the dominant one in the family. She was ready to criticize every action of each member. On the initial visit, although the father was there, she did all the talking. She said her husband always permitted her to do what she thought was best about the children, as he was away most of the time. The mother bit her finger nails. The younger brother was the mother's favorite, although he had a reputation for being mischievous and telling fantastic tales.

History. The mother's pregnancy and the patient's birth were normal. He was breast-fed, but when he was weaned there was difficulty in finding a formula that agreed with him. His bowel training started at four months. He walked and talked at nine months. Shortly before he was three years old, he had bronchitis and a tonsillectomy, the latter followed by numerous nosebleeds from which a slight anemia developed.

Examinations. Careful physical examination revealed no organic pathology. The patient was self-conscious and restless during his psychological examinations. He complained that his eyes hurt and rubbed them whenever he was asked questions. He was not spontaneous and often refused to answer. No definite I.Q. was reported.

With the psychiatrist the patient was friendly and talkative. He often answered questions in a contradictory fashion, and usually the second answer seemed to be more correct. He said he liked his daddy most but that he was more scared of him than of anyone else. He had dreamed that his father was in bed with him. He does not like his father to sleep with his brother. With great reluctance and much embarrassment, he confessed that he had great difficulty falling asleep. In fact, each night it usually took him one or more hours to do so. This difficulty was due to a fear that a big black bear would attack him after he got into bed. (It seems probable that the reason he was so morbidly fascinated by noises at the back of the house was that he was looking to see if the bear was really there.) He said that he wet his bed because he was afraid to get up at night. He did not like girls.

Diagnosis. The boy's phobia of bears, his fears of noises in the night,

his curious relationship with his father and uncle, his dreams about his father, his behavior in school, his fear lest he wet himself and his frequency (his mother threatened that he could not come to the clinic if he wet his pants, so he went to the toilet four times during breakfast and several times before entering the clinic), his fear lest he do the wrong thing, his constant changing of answers to questions as if he did not want to give the correct answer, and his inability to go to sleep—all indicate that he suffers from marked feelings of anxiety. The fact that he has a phobia as well as feelings of anxiety makes the diagnosis one of anxiety hysteria. The three nocturnal attacks of pain indicate that he has converted some of his anxiety into physical symptoms. This does not change the diagnosis to conversion hysteria. The differentiation between conversion hysteria and anxiety hysteria often has to be made on the principle that if phobias are the most pronounced symptom, the patient suffers from anxiety hysteria; if conversion symptoms are most pronounced, the patient suffers from conversion hysteria.

I mentioned earlier that there is no real diagnostic distinction between so-called chronic anxiety states and anxiety hysteria because in the former the child always suffers from phobias but may not have mentioned them to anyone. I knew one boy who only after a year of intensive treatment told me that every night, as soon as he put the light out, several weird animals, among which was a five-headed dog, came into his room and stood looking at him while he lay shaking with terror in his bed. One of the reasons why children are too embarrassed to tell about these dreadful phobias is that the phobias are sexual in nature and the child unconsciously fears that if he mentions them, his unconscious sexual thoughts and feelings will be discovered by himself and by others.

The inciting cause of the anxiety hysteria was the coming of the aunt and cousin to live with the family. Though the inciting circumstance seems very slight, the history indicates that the boy was sensitized to such a situation. He was already suffering from a mild chronic anxiety state to which he could make some adaptation until the extra burden of the relatives broke it down.

Psychopathology. The chronic anxiety state was the result of a number of factors:

1. The early weaning and the feeding difficulty that followed. He would feel the former as a deprivation and the latter, because of the discomfort, as a source of unhappiness and insecurity. (It is interesting to note that he has had a tendency to use an unwillingness to eat as a

method of getting his mother's attention, which indicates that the early feeding difficulty upset both him and his mother a great deal.)

2. He had bronchitis, an operation, and his brother was born when he was three. We do not know how he felt about his brother's birth, but it is probable that he received more attention during his illness and consequently would have more difficulty in adjusting to the mother's attention to the new baby.

3. There have been many changes of residence. A small child feels these moves intensely. He dislikes leaving a familiar house and neighborhood and going to a new one and is made unhappy by it. Abraham¹ long ago pointed out that the house is an important symbol of the mother to the young child and having to leave his familiar house is the same as leaving the mother.

4. The mother has not helped the boy to feel secure with her. She prefers the younger brother. She has been kind to the patient but has laid down a rather strict code of behavior.

Because of the boy's age and insecurity with the mother he is strongly attached to her. In order to be more secure, he would like to have her all to himself. Often he has this opportunity because his father is away so much. He is upset and annoyed when the father comes back. As was noted under the symptoms, he has a good feeling toward the father when the latter is away but is extremely frightened of him when he returns. (When a child who shows a definite fear of some person comes for treatment, it is important to determine first whether there are present and real reasons for the fear, regardless of the familial, social, or community position of the person feared. If this can be excluded, it should be determined whether someone who is of the same professional or social group as the feared one has acted in a way to frighten the child. If this in turn is excluded, then attention must be turned to the child's intrapsychic reaction to the feared person.) Because of the boy's attachment to the mother he feels very jealous and hostile toward the father and wishes to interfere in the relationship between them and to kill, maim, and drive the father out. In turn he has the idea that the father has a similar feeling toward him and will retaliate, feeling that in retaliating, the father would only be acting justly toward him. In other words, he projects his own hostile feelings onto his father and then fears them as if they really were those of his father. And as long as he retains his attachment to the mother, his unnecessary fear of the

¹ Karl Abraham: *Selected Papers on Psychoanalysis*, Hogarth Press, London, 1927.

father will persist. His fear of the father is seen plainly in a hideous picture he drew to represent him. His father has been kind to him, although he has contributed to the boy's antagonism by objecting openly to the mother's babying him and to his fear by his strictness. The boy loves his father, also, but accentuates this love in order to deceive the father as to his hostile feelings.

The boy, then, is torn between unconscious conflicting feelings toward his father—antagonism, fear, and love—and as yet has reached no solution to the conflict except to feel anxious constantly and to project the feared conflicting feelings onto a fantasy bear. With this conflict situation in full blast, two more rivals for his mother's affection appear on the scene and the boy's conflicting feelings are suddenly brought to a head and overwhelm him. As a result, he is unable to stay in school because it keeps him away from his mother.

It is well to point out here that truancy resulting from such conflicts is not uncommon. The child stays away from school, and does not go somewhere else to amuse himself but remains at home. Instead of being angry if forced to go to school, he becomes extremely frightened and cries piteously, clings to his parents, or hides under the bed. I would designate this form of truancy as neurotic truancy or truancy due to anxiety.

PSYCHOPATHOLOGY OF A PHOBIA

The best study of a phobia in a child still remains that of Little Hans, reported by Freud in 1909.² This study should be read carefully by physicians who have to deal with such cases. A five-year-old boy suddenly refused to go on the street because he was afraid of horses. His unwillingness to leave the house, where he seemed contented, happy, and fear-free, either alone or accompanied, was an attempt to avoid his feelings of fear. (Similar inhibitions of activity result from all phobias but are only secondary to the phobia and have nothing to do with its structure. This is important to remember because there is no advantage in trying to treat the inhibitions, as is frequently done. Such inhibitions are seen most frequently in regard to going to school or playing with other children. Rather than try to treat the inhibition, it is more important to try to understand the phobia underlying it.) The fear of horses consisted of two parts—a fear that a horse might fall down and a fear that

² Sigmund Freud: "The Analysis of a Phobia in a Five-Year-Old Boy," *Collected Papers*, Hogarth Press, London, 1933, Vol. III.

a horse might bite him. The boy recognized and could discuss the former with greater clarity and ease than he could the latter; i.e., the latter was the more important nucleus of the phobia. It should be noted that there is a reality element to the fear that a horse might bite him. Horses do bite, but such occurrences are so infrequent that a child usually does not consider them. These two fears were projected expressions of the boy's conflict in his feelings about his father. He was jealous and hostile toward the father and toward his younger sister and wished that he could bite them both and that they would both fall down—or die. This aggressive hostility was the result of his strong attachment to his mother, which made him desire to possess her wholly himself, without having to share her with anyone, and to obtain from her not only all the physical manifestations of love and tenderness which he already had but also all that she gave to his two rivals. He feared these hostile feelings for two reasons. He was afraid that if his father knew about these hostile wishes, he would become angry. Being bigger and stronger, he would then inflict on the boy by way of punishment the same misfortunes as the boy wished on him. He loved his father and knew that if he injured or killed him, he would not have any father to love him. In the face of the fear of injury at his father's hands and loss of his loving care, he attempted to repress his hostile feelings and was successful in that they did not seem to exist toward the father but only in a confused fantasy about horses.³

A second case of Freud's illustrating the mechanism of the phobia is also available to the interested physician.⁴ During childhood, the patient suffered from a phobia of a wolf whose picture he had seen in a book. He was afraid that the wolf would eat him up, as happened in the story of the Seven Little Kids. This fear of being eaten by the wolf

³ I have encountered only one attempt to establish a different psychopathology for the phobia of Hans than that established by Freud. Allen (Frederick H. Allen: "Homosexuality in Relation to the Problem of Human Differences," *American Journal of Orthopsychiatry*, 10:129, 1940) believes that Hans's fear was not that he would lose his penis because of hostile feelings toward his father but that the fact that he had a penis made him different from his mother. He regarded being exactly like her as the sign of a gratifying love relationship with her. As Allen says, "Growth was the breaking in on the totality of his relation [his desire to be like his mother and so have her love him] and neither he nor his mother was ready for it." Such a formulation does not take into account the fact that Freud proved that the horse was a representation of the father and only secondarily of the mother.

⁴ Sigmund Freud: "From the History of an Infantile Neurosis," *Collected Papers*, Hogarth Press, London, 1933, Vol. III, p. 473.

was a fear of being eaten by his father and represented two conflicting ideas. He wished that the father would love him as much as the father loved his mother but realized that if he admitted such a wish he would have to be castrated as his mother was. In order to avoid this realization, he regressed in his thinking to an oral stage of object relationship where the desire to love and be loved was represented by the act of eating or being eaten.

Freud has fully discussed the nature of phobias, particularly animal phobias, in *The Problem of Anxiety*,⁵ where he states that the ego must intervene against the expression of internal libidinal desires toward an object if it believes that to yield to these desires entails the danger of castration. In the case of the man who had had a wolf phobia, as a child he had realized that the passive feminine desires toward the father brought him at the same time into danger of wishing for castration. In the case of the boy afraid of horses, the ego realized that the erotic desires toward the mother brought him into a rivalry situation with his father, whom he loved and whose anger he feared. As soon as the ego recognizes the danger of castration, it gives the signal of anxiety and, through the pleasure-pain mechanism, inhibits the threatening libidinal process in the id.

The inhibition is performed by replacing the real object (the father) by a substitute (the horse or wolf) and by a distorted expression of the impulse. The substitution of the animal for the father has two advantages:

1. It enables the child to avoid the recognition of his conflicting feelings about the father.
2. It allows the ego to prevent the further development of anxiety, since anxiety is felt only when the phobic object—i.e., the horse or the wolf—is present. As long as the phobic object is not present, the anxiety reaction does not occur.

Freud believed that the reason why animals are so frequently selected as phobic objects is that they are so free in exhibiting their genitals. This makes them interesting objects for the child to study.

THE PROGNOSIS OF ANXIETY HYSTERIA

What are the results of untreated serious phobias in children? Reich⁶

⁵ Sigmund Freud: *The Problem of Anxiety*, W. W. Norton & Company, Inc., New York, 1936.

⁶ William Reich: "Character Formation and the Phobias of Childhood," *International Journal of Psychoanalysis*, 12:219, 1931.

points out that the development of a phobia is a sign that the ego has been too weak to control the instinctual urges and in this weakened condition projects the inner strivings onto an external object. This implies that there has occurred a splitting of the personality. Part of the personality is rejected and projected and part is retained. The phobia is really an attempt at self-cure, but the ego has to strengthen itself constantly in order that the cure—i.e., the avoidance of the internal conflict—may be maintained. This is done by the overdevelopment of character traits that are of use to maintain the split—which is what occurred in the case cited by Reich, where the patient felt no affect of any kind. This was the result of his stopping his frightening dreams of a horse biting him, by the resolve never to dream them again. He was able, in turn, to make this resolve because his early character formation during the anal-sadistic phase of development was compounded of his anal obstinacy and his parents' oversevere demands that he control himself.

There are other ways in which the ego is able to maintain the status quo and so avoid the inner conflict, but these two examples serve to demonstrate an important fact. Once the ego has had to deal with the inner conflicts by the mechanism of a phobia, it remains permanently unable to solve the conflict in a more economically adequate fashion and the individual remains permanently hampered in his development and his relation to reality. We have already noted the fact that adults with phobias have very immature egos, which fact is particularly true in those cases where the phobic object is imaginary and not a really dangerous one.

THE DEVELOPMENT OF A PHOBIA

Phobic reactions are possible only after the child has reached the phallic stage of development. Until the penis has been recognized as an important part of the body, the child cannot have come under the sway of the fear of castration. Regression to an earlier level of development may occur as a result of the castration fear, but this, like the inhibitions of activity, is the result of the difficulty that produced the phobia.

Here is a case illustrating a phobia in statu nascendi.

CASE 22. A five-year-old boy is referred because he is moody and has periodic headaches which began about six months prior to his referral, shortly after his father and mother separated. While playing, he often stops and broods. He has nightmares about once every three weeks.

There are no other signs of fear—in fact, he seems a little too unfeeling. He is usually the leader of his group. Although he did not seem to be particularly close to his father, he now cries because his father is absent. He talks like his father and seems to be developing the same interests.

History. The boy was born at the end of a nine months' pregnancy after a twenty-two-hour labor which had to be assisted by instruments. He got his first tooth at seven months and walked and talked at fourteen months. He never crawled. He was breast-fed for four months and bottle-fed for the next sixteen, the diet supplemented by solid foods from the fourth month on. His appetite has always been excellent. He learned bowel control at eighteen months and bladder control by two years in the daytime and by three years at night.

His father was an alcoholic who arrived home drunk one night and started to punch and beat the child so severely that the mother went out to call the police. When she returned, she found the father lying on the stairs foaming at the mouth. The next morning, the father did not believe he had abused the son until he saw the bruises on the boy's body. He became very remorseful, told his wife that it was dangerous for him to stay with his family, and left home that day.

Examinations. Examination of the boy was negative for any organic disease. His psychometric exam showed he had an I.Q. of 111. At the beginning of the interview with the psychiatrist, he was very talkative and quite aggressive. Toward the end he became very restless, began to cry, and complained that he was hungry. He told a number of fantasies about his father: he did not miss him because he came every week to take him to his place of work; the father had a room in the house which he used as a place to hoard his money; in any case, he was going to get a new father. He told a story of having beaten up a man and went on to say that when he grew up he was going to be an Indian and hunt lions and tigers, after which he was going to use them to ride on, and perhaps he would collect the animals and lock them up in cages.

Psychopathology. The boy's moodiness was due to his separation from the father, particularly to the circumstances under which it occurred. The severe beating made him very resentful and antagonistic to his father and increased his fear enormously. The fact that the father left the house because of what he had done to the boy increased greatly the boy's fear of the results of his aggression. He felt unhappy over the separation and lonely for the father. He was conscious of the latter feeling and was making an endeavor to feel less lonely for the father

by trying hard to be like him. If he could not be *with* father, he could *be* father and therefore not separated from him. In his story to the psychiatrist, he dealt with his loneliness in several ways. He denied missing him, stated that he had no need to miss him since he saw him every week, that he retained a room in the house in which to hoard money, and so on. These denials, however, were not only for the purpose of assuaging his feeling of loneliness for his father. They were also denials to reassure himself that it was not his own aggression that drove the father away. The mechanism of reassurance through all kinds of denials was not completely effective. It did not help him to lose the fear of his own aggression. He said he had beaten up a man, which was a reversal of the reality and was fantasied because he wished he had been able to beat up his father. He then became afraid of this idea. He would be an Indian (a bad, cruel person) and go and live with Indians (because he was only fit to associate with bad people). He wanted to hunt lions and tigers (the projected symbols of his own strong oral aggression and that of his father). He would kill them (destroy his own aggression and his father). He would ride on them and confine them in cages (be master of his own aggression).

The projection of his aggression took four successive steps. At first it was completely internal; e.g., he was an Indian. Therefore, because he was too dangerous to live in a civilized country, he would have to leave and live with the Indians. But he did not wish to go away from home. He therefore projected the aggression in the symbolic form of lions and tigers; but the aggression was not completely projected, for he rode on these animals. This, he felt, would not work very well; the attached aggression might cause him trouble, so he proceeded to detach it from himself and try to control it by caging it. Still it was too dangerous, so he detached it completely from himself and from his environment by putting it out in the woods where he would have to hunt for it; but now the only way he could deal with it would be to destroy it. However, as long as his aggression was far away roaming the woods, he did not need to be afraid of it unless he went and hunted for it. Nor did he need to feel it would produce dangerous and painful results in his environment since it no longer existed there.

Thus the lions and tigers served as symbolic scapegoats for his aggression, the choice of animals indicating that he feared his aggression in two ways: he feared the power of his hatred of his father—his desire to destroy him by tearing him to pieces and eating him up; and he feared the power of his passive love for his father—his desire to be

eaten up by him and so be made a part of him. When the projection of these two desires onto the lions and tigers had been made complete, he would be conscious of neither of these feelings toward his father. Only if he saw or perhaps heard about lions or tigers would he become overwhelmed by fears of these animals, which fears would constitute a phobia. Thus by means of this projection he is able to live comparatively comfortably. I say "comparatively" because the projection can never be completely successful, since the lions and tigers can return in his dreams.

Here then is a phobia in the process of development. When full-grown the boy will have an inordinate, excessive panic about lions and tigers. Attempts to argue him out of the panic will be useless because his unconscious is speaking of something else and therefore he can say, and rightly, that all people should be afraid of lions and tigers, for they are dangerous animals. Furthermore, attempts to condition him to like and not be afraid of lions and tigers might result in his becoming unafraid of these animals but soon developing a phobia of something else. Neither of these methods of treatment can, therefore, be successful because they do not touch the real problems—his fear of the power of his hatred for and his love of his father.

THE DIAGNOSIS OF ANXIETY HYSTERIA

It is necessary to distinguish a phobic reaction from a fear of an object that has actually injured the child—i.e., a conditioned fear. A child who has been attacked and badly bitten by a dog, for instance, will continue to fear all dogs for some time, but gradually he will learn to distinguish between dogs that are dangerous and dogs that are not. The psychotherapy and treatment of such a case will be different from those in the case of a child with a phobic reaction. The diagnosis of a phobia is usually not difficult. The child complains of being afraid of one or more objects and shows fear in his behavior. Examination shows that the fear reaction is greater than the nature of the object warrants. At times it is easy to obtain an accurate history of the attack; at others it is difficult, particularly when the feared object is a human being or when the frightening situation occurred under forbidden circumstances. A child may have been brutally hurt by an adult or older child who at the same time threatens the child with reprisals if he tells. Under those circumstances, when questioned he tends to deny any cause, even though he is conscious of the whole situation and has to continue to live with it.

The guilty person will, of course, deny his act. Too, if the child has been hurt by an older child or adult during a forbidden activity, the child, though frightened, will also be too afraid of punishment to tell his experiences. This is particularly true when the forbidden act is a sexual one. A little girl may suddenly become afraid of a particular man or of all men. When asked why she is afraid, she will deny knowing the reason. Later, perhaps years later, it will be learned that the man seduced her and injured her painfully during the sexual act, she having denied her knowledge because of fear of punishment for her participation and fear that he would retaliate. Although she experienced pain and suffering during the act, she also experienced a pleasurable thrill which she hoped would be repeated but knew would not be if she told.

This type of case—i.e., where there is a real cause for the fear but the child is unwilling at first to reveal the experiences that caused the reaction—is difficult to differentiate from a phobia. Therapeutically it is better to treat it as a phobia because during such treatment, as the child develops confidence in the therapist, he will reveal his real life as well as his feared conscious and unconscious desires. It must be remembered that some of the experiences, particularly sexual ones, related by a child as to his treatment by others may be fantasies of what he wished to happen, and it requires careful judgment to determine whether the experience related by the child was a real or fantasied one. However, treatment is the same as for a phobic reaction because the aim of such treatment is to make the child better able to handle himself. More important still, the therapist should not dismiss the report as unimportant, whether it is real or fantasied.

Jersild mentioned that in fifty of his four hundred cases the patients reported that they had been made afraid of an object by another person. If the child loves the other person a great deal, he may take over the other's fear as part of his identification with the loved person, children often expressing their love through identification. If the child fears the other person a great deal, in order to get on with him he may accept the other's fears. In this situation he will show the fear only when the other and dreaded person is present. Of course, both of these attitudes should be corrected through a growing recognition of reality and through the constant process that goes on in every child of subjecting what he hears to what he has observed himself. Identifications, however, are usually too stable to be affected by the knowledge of reality. The case again should be approached through treatment as a phobic reaction

during which the identification and the fear constellation can be removed.

We have already discussed the common belief that movies, radio programs, and stories cause anxiety attacks in children and have learned that they do so only when the child is psychologically ready to form a phobia. The story furnishes only the selection of the object onto which the child projects his inner impulses about which he is already in conflict. I am acquainted with an intellectual but neurotic adult who was in serious conflict over his ambivalent reactions to his father and who experienced so much terror that he could not sleep after seeing the movie of the *Three Little Pigs*. He was so affected only because he was psychologically disturbed before he saw the picture. Parents often unnecessarily restrict their children in regard to movies, radio programs, etc., because they are apprehensive lest the child become frightened. They do not understand or perhaps may not wish to understand that it is the child's developmental problems that are producing the fears. The parents' unwillingness to understand is more pronounced when they are unnecessarily interfering with the course of their child's development. A parent who has actually threatened the child with castration because of masturbation and so produced a great internal conflict in the child's mind would rather believe that the anxiety attacks are due to a frightening movie or radio program than to his mishandling.

Another diagnostic problem arises when the child, apparently without reason, inhibits some activity and shows extreme terror when forced to carry it out. Such a case should be treated as if the child had a phobia—as he probably has.

TREATMENT OF THE PHOBIC REACTION

Parents often have their own methods of dealing with the phobias of their children. Jersild and Holmes⁷ made a study of the methods used by parents and teachers to overcome the fears of children and tried to evaluate their relative success. They found that the following were the usual methods.

Before a child is presented with an unfamiliar object or situation, (1) the nature and safeness of the object or situation are explained to him, and shortly before meeting it he is forewarned either directly or indirectly; (2) a demonstration or example of the safeness of the object

⁷ Arthur T. Jersild and Frances B. Holmes: "The Methods of Overcoming Children's Fears," *Journal of Psychology*, 1:75, 1936.

or situation is combined with an explanation similar to that used in method 1; (3) the adult presents a casual attitude toward the object or situation, with or without any of the explanations used in methods 1 and 2; (4) the child is helped to learn skills that enable him to deal with the situation or object; (5) the dangerous or possibly dangerous objects or situations are not presented to the child until he has acquired through growth the necessary skills to deal with them; (6) certain parents, in order to be sure that their child will never be frightened, keep him away from all dangerous or possibly dangerous objects or situations.

The authors divide the methods used to overcome fears that are already present according to their effectiveness.

A. Practically ineffective:

1. Ignoring the child's fear.
2. Forcing the child into contact with the feared object or situation at frequent intervals. (Although the authors do not say so, this method is based on the application of a greater fear to force the child to overcome a lesser one. When the child is forced by his parents into a situation he fears, he complies only because he is afraid they will dislike him or punish him if he resists. In order to retain their good graces, he denies to them and sometimes to himself that he is afraid of the situation. This is a very commonly used method and at times is apparently successful.)
3. The removal of the feared object or situation or the offer of palliatives to the child.

B. Measures that are sometimes helpful in enabling the child to overcome his fears:

1. Verbal explanation and reassurance.
2. Verbal explanation plus a practical demonstration that the feared object or situation is not dangerous.
3. Giving the child examples of fearlessness regarding the feared object or situation. (In using this method, parents frequently quote the example of other children, the result sometimes being to make the child very antagonistic toward the parent: the parent talks as if he preferred the other child, which makes the child hostile toward the other one, whose very name becomes anathema.
4. Conditioning the child to believe that the feared object is not

dangerous but really pleasurable. (This method would be very valuable if the child were afraid of the phobic object only through ignorance or previous conditioning. If the child's phobia is the projection of an internal conflict, it results in relieving the child of the fear of the object but the anxiety now freed from the object may overwhelm him, as in a case I have reported elsewhere.)⁸

C. The methods found most effective in helping the child to overcome his fears:

1. Helping the child to develop skills by which he can cope with the feared object or situation.
2. Taking the child by degrees into active contact and participation with the feared object or situation.
3. Giving the child an opportunity gradually to become acquainted with the feared object or situation under circumstances that at the same time give him the opportunity either to inspect or to ignore it.

Children overcome fears even without help, either as part of the process of growth or through the following procedures: (1) They practice overcoming their fear through enlisting the help of adults or their favorite toys. (2) They talk about the things they fear with other people. (These measures are really most effective when used as auxiliaries to the next group.) (3) They argue with themselves about the reality or unreality of the dreaded imaginary creatures or fantasies about the events—say death—that they fear.

The authors feel that the child overcomes his fears more often through his own efforts than through those of his parents or teachers. These methods pay little or no attention to the anxiety element in the child's fear. They are effective only because their use coincides with certain changes perhaps produced by inner or outer but at best unknown factors in the intrapsychic equilibrium.

SPECIFIC METHODS OF TREATING THE PHOBIC REACTIONS

The psychopathology of the phobic reaction is that the child's ego feels helpless because it is unable to solve the struggle between the child's opposing feelings of love and hate toward the same person due to the arousal of erotic needs. Specific treatment, therefore, is directed

⁸ O. S. English and G. H. J. Pearson: *The Common Neuroses of Children and Adults*, W. W. Norton and Co., New York, 1937, p. 77.

toward helping the child understand his inner feelings, with the anticipated result that the ego, by becoming aware of the instinctual impulses, will be strengthened in its ability to deal with them.

Before the specific treatment of the child can be considered, it is necessary to survey the whole situation in which the child lives, because the child is dependent on the support and domination of the adults and older children and is, therefore, not a free agent. There is always the possibility that the physician will have to deal with two problems—first, the child's own intrapsychic one; second, the use the child and his parents and teachers are making of his intrapsychic problems to gratify their desires in the interpersonal relationships. It will perhaps be best if I discuss the direct treatment of the child's own intrapsychic problem first and then later the manner in which that treatment may have to be modified because of the interpersonal relationships in the family.

METHODS OF DIRECT TREATMENT OF THE CHILD WHO HAS A PHOBIC REACTION

It is interesting that all the specific methods for the treatment of phobic reactions are developments and variations of the various methods accepted and used by Freud in his treatment of Little Hans's phobia.

THE CONVERSATIONAL METHOD

The first question that arises is, Who shall treat the child? In the case of Little Hans, the treatment was carried on by the father under Freud's direction. Such a method overcomes one very difficult problem: there is no need for the child to develop a relationship and friendly filial feeling toward a new person. Of course Hans's father was a trained person and understood what Freud was trying to do with the child, and such situations are not common. However, I am acquainted with a father who was able to deal with his son's anxiety attack himself.

CASE 23. His eleven-year-old son began to show restlessness at night. One night the parents heard him crying, and when the father asked him what the matter was, he said he feared he could not go to sleep. Though the father knew the fear was absurd, he thought over the situation and remembered that for several weeks the boy had had no playmates, all his friends having gone away on vacation. He also remembered that for several days the boy had seemed lonely and could not find anything to do to amuse himself, although he had tried very hard. The father concluded that the boy was feeling lonely and bored and knew that at

such a time the need to masturbate would be very strong. Also, he realized that the boy was becoming adolescent and would be more conscious of his need to masturbate than previously. Although neither of the parents had ever criticized the boy's infantile masturbation, the father knew that the friends' parents had very rigid ideas on the subject. He surmised that the boy and his friends had discussed the question of sexual relations and masturbation and that their ideas would reflect their parents'. He sat down with the boy and told him that he thought his anxiety attack was connected with his growing up. He explained the physical changes of puberty, the increasing frequency of erections, the pleasurable sensations that arise from touching the penis, and nocturnal emissions. He explained further that many boys are frightened the first time they have a nocturnal emission because they do not understand its cause, that they think something terrible is happening to them, that the fears are groundless because the emission is the result of a harmless physiological process. He explained that many boys think it injurious to masturbate and have all kinds of silly fears connected with the act. He said he was sure certain of his friends had such ideas and that they had discussed them with him, that the ideas were erroneous, for masturbation is a harmless act. The father went on to say that during the act of masturbation there are also fantasies about sexual relations with girls and often fantasies of antagonisms toward other men and boys, often toward a boy's own father, but that such fantasies are perfectly natural and common and that he, as the boy's father, would not be angry if the boy thought such things. The conversation lapsed at this point. The boy immediately seemed happier, and from that day on was untroubled either by feelings of anxiety or sleepless nights.

Not to diminish the real cure that took place, it would nevertheless have been better for the father to help the boy express his own ideas and thoughts about these problems and to help him correct his erroneous ideas and misapprehensions, which is what was done by the father in the case of the six-year-old boy who had a traffic phobia, reported by Kubie.⁹

The conversational method was part of the technique used by Freud with Little Hans. It can be applied by the parent, provided he is well enough trained to understand what the child is relating and to listen patiently when he does not understand, knowing that if he waits long

⁹ Lawrence S. Kubie: "The Resolution of a Traffic Phobia in Conversations between a Father and Son," *Psychoanalytic Quarterly*, 6:293, 1937.

enough the child will make his information clear. If the therapist is the physician, the conversations must be preceded by a period during which a friendly, understanding relationship is built up between the two.

The reader will note that I have said that the conversational method can be applied either by the parent or by the physician provided they are well trained. By "well trained" I mean they must have had psychoanalytic training which has enabled them to understand their own unconscious and their own childhood. Anyone who has not had such training and attempts this method of therapy with a child may do great harm.

The conversational method of treatment is of greatest value when undertaken very soon after the phobic reaction occurs. Also; it is most applicable to those cases where adventitious circumstances have heightened the conflict of the normal Oedipus situation, for such circumstances are important in precipitating the onset of the anxiety attack. In Case 23, the boy had been accustomed to seeing his friends daily and the sudden separation made him feel lonely, depressed, and frustrated, which precipitated the anxiety attack. In the case reported by Kubie, the precipitating factors were a move to a new neighborhood and the leaving of the nurse who had been with the boy for six years. In both cases the parents had raised their children without too much strictness or severity and their attitudes had been loving ones.

When the parental attitudes have not been understanding and loving, the immediate cause of the anxiety attack is complicated by a long history of interpersonal difficulties and the methods the child has evolved to solve them. Therefore a cure cannot be expected by the simple conversational method. In brief, the conversational method promises most success when used by a therapist with whom the child is already in a positive understanding relationship, in those cases where the attack has been of brief duration, where it has been incited by adventitious circumstances and under conditions wherein the parents have been understanding and loving and have trained the child in an intelligent manner. During the course of the conversational method the child will act out some of his feelings and fantasies in his play. As Freud noted, Little Hans began to play out of some of his aggressive ideas in his play. This is really a necessary part of the treatment and has been developed into a form of treatment by Levy.¹⁰

¹⁰ David M. Levy: "Release Therapy," *American Journal of Orthopsychiatry*, 9:713, 1939.

RELEASE THERAPY

The observation is almost axiomatic that motor activity has the purpose of relieving the inner tensions that result from sensory stimuli arising either outside or inside the body. When stimuli arise within the body and cannot be expressed motorially, there arises a feeling of anxiety. Bernfeld states that the child is able to still the pain and anxiety connected with his mother's leaving him by learning to walk and so being able to leave her—to do to her as she has done to him. A certain amount of the play of children represents such an attempt to get rid of anxiety feelings.

CASE 24. A boy of three was very lonely when his parents took a winter vacation and left him with the maid. During their absence he was severely frightened by the teasing of his older cousins and as a result developed an acute attack of anxiety. During treatment, after he felt friendly toward me, he acted out the following play over and over: He ran a toy bus out of the playroom into the hall, closing the playroom door behind him so that I was left alone. After a varying period of time, he came back. Then he repeated the performance with the bus, a cart, or an airplane. He told me he was going to Florida—where his parents had gone—and that I was not to come. As the play progressed, he even made me lock the door behind him so he could be sure I would not come to him. By thus actively going away and leaving me alone to whatever might happen to me he was trying to overcome the fear and anxiety that he had to endure passively when his parents left him alone.

Levy has developed this method into a technical procedure to cure the symptom of anxiety in specially selected cases of anxiety attacks. The method is effective when the child has developed an anxiety attack following a specific known frightening event, the attack having begun only a short time before treatment, and when his environment is free from family problems. The psychiatrist sets up a play situation resembling that which the child had to endure passively and has the child do to a doll what was done to him. It is often necessary to encourage the child to take part in the play or to continue the play to its ultimate conclusion even though he is taking the active role.

Besides this therapeutic measure, which allows a release of feeling in a specific play situation set up to resemble a definite experience in the life of the patient, Levy also uses the method in two other situations: (1) If a child seems greatly inhibited, he is encouraged to play with clay or water, destroy balloons, etc. This allows the child a simple re-

lease of infantile desires, with the permission of an adult, which he has been unable to gratify because his parents have unnecessarily forbidden him to gratify them. Mrs. Rank¹¹ calls this type of therapy "educative therapy" and believes it has great value for children under the age of three. In addition, for many children between the ages of three and five it serves as a valuable method of introduction to their psychoanalysis.

(2) There are certain situations in every child's life that may produce conflicting feelings which result in anxiety states: the birth of a new baby, the display of affection or sex relations between the parents, and the sight of a naked child of the opposite sex. Levy sets up a dramatic representation of these situations and encourages the child to dramatize what he would do¹² if he were confronted by one of them.

CASE 25. An eleven-year-old boy was brought for treatment because he was afraid to play with other boys of his age. There was much evidence of an unconscious hostility toward his six-year-old sister. During the course of treatment, when it appeared timely to consider this rivalry, a scene was set up. Breasts of clay were placed on a female doll to represent a mother, and a baby made of clay was placed in her arms with its mouth to her breast. Another doll was designated as a boy who walked into the room and saw the mother nursing the new baby. The patient was asked what the boy would do. He waited a minute and then said he would go over and look at what the mother was doing. He was asked "What next?" He would take the baby and put it in bed in another room and lock the door so the baby could sleep quietly. What next? He would run away. I reassured him that the mother would not be angry whatever he did and urged him to go on. He would climb up to the baby's window and, pretending he was a wolf, frighten the baby. What next? With some encouragement, he said he would stamp the baby into the earth, eat it up and then take it out in the woods and bury it. What next? He would take all the baby's toys and put them in the toy box and run away. After further encouragement, he said he would go downstairs and get a saw and cut up the baby's bed and hide it in the woods. What next? He would come home, and he and his mother would go to bed together, piling a box and trunk against the door to keep a wild Indian out. (Of course, the wild Indian represented his own guilt about his aggressive feelings toward his sister—more specifically the

¹¹ Discussion during the Meeting of the Discussion Group on Indications and Criteria for the Psychoanalysis of Children and Adolescents. American Psychoanalytic Association Meeting, Washington, May, 1948.

¹² David M. Levy: *Studies in Sibling Rivalry*, monograph No. 2, National Committee for Mental Hygiene, New York.

avenging ghost of the dead sister. More deeply in the unconscious it represented fear of his father.) This case shows how deeply buried but how enormous was this boy's hate for his sister and how it was possible to bring it to the surface through release therapy.

It is not always necessary to set up a dramatic situation for the child. In fact it is often advisable to allow the child to select his own toys and let him make his own dramatizations. As he continues to do this, observations of his play will indicate the nature of the current conflict, which he can then be encouraged to play out.

PSYCHOANALYSIS

The model for all psychoanalytic therapy of phobias in children is Freud's analysis of the case of Little Hans. Guided by the material produced by the boy, the analysis followed definite steps as it proceeded from one level to another. Freud felt it was necessary first to discuss with the boy the facts of the situation, which had been made available from the observations made and reported by the parents before the phobia developed. The boy was afraid of horses—at first lest they fall down and later, and more accurately, lest they bite him. Since this was not the real cause of the phobia, as a preliminary step it was necessary to convince the boy that his fear of horses was nonsense. This preliminary step is necessary in beginning the psychoanalytic treatment of all phobias in children. The patient has to be told what he is really afraid of. Hans was told that the reason he was so afraid of horses was that he was so preoccupied with penises, that he felt he had no right to be so preoccupied, that he was too fond of his mother, wanted to be with her all the time, and particularly wanted to be taken into her bed. Since it was felt that the aim of his desire to be taken into his mother's bed was to see her penis and since this aim had to be taken away, he was told that a girl does not have a penis—a fact he had refused to accept for several years. The boy reacted to the first part of this interpretation by becoming interested in looking at horses from a distance; to the last part by a slight improvement in his phobia but with a vigorous denial that what his father said was true. It seemed evident that this vigorous denial was a protective measure, since to admit that a girl has no penis would shatter his self-confidence and mean that his mother's castration threat might really be carried out.

This situation was followed by a dream which gave further material, since it revealed that he was afraid his mother would not like him because his penis was too small. Also it expressed a desire to do something

forbidden. The forbidden thing was, of course, his longing for his mother, which he felt had been forbidden by his father. The real situation—i.e., that he was afraid not of horses but of his father because he loved his mother so much—was discussed with him. He reacted to the discussion by bringing out clearly his ambivalent reaction to his father and in addition another fear; i.e., that his father would leave him. This ambivalence was based on a conflict of two impulses: he was afraid of his father and was afraid for his father's safety; i.e., he felt hostile toward him, yet loved him and did not want to lose him as a result of the hostility. After this was discussed with him, he began to abreact some of his feelings. Although still afraid of horses, he began to play he was a horse. Here he was beginning to identify himself with the father. The material now changed. He began to express his conscious disgust with his now unconscious but formerly conscious desire to be so intimate with his mother as to be able to see her move her bowels. Whereupon he brought up one of his earlier fears, i.e., that of the horse falling down. This was associated with a fear of defecation, i.e., an interest in seeing the feces falling—a concern lest his mother let him fall at his birth, i.e., his infantile birth theories, and a wish that his mother would drop his younger sister into the bath and let her drown. Here again was the fear of his hostile wish against his rival. The discussion of this new material allowed him to express verbally certain sadistic wishes to beat and tease horses. They seemed to be better tolerated by him when directed toward the mother and were partly the expression of an obscure sadistic desire for the mother, but they were really directed toward the father and were an expression of a clear impulse to revenge himself on him. There was also revenge against the mother, for he began to wish to have a child of his own and to wish that his mother would not have one. He became intrigued with the question as to whether people liked or did not like having children. The basis for this concern was, of course, the question as to whether people liked or did not like moving their bowels. Satisfied on this account, he began to fantasy that he had a large family whom he would look after as his mother had looked after him. In this fantasy he compensated for his unsatisfied passive longing to be fondled by his mother by an active longing to fondle others. He then solved his conflict over his jealous rivalry with his father by fantasizing that he would marry his mother and then his father would be his grandfather, and by dreaming that his father could not castrate him for his hostility but instead would give him a bigger and better penis. After

he produced these ideas his phobia disappeared and his relationships with his parents became normal.

Freud calls attention to three important points. First, the boy suffered from a phobia. His anxiety dared show itself boldly because he had been brought up by understanding parents, and so the anxiety situation was not complicated by a guilty conscience or a fear of punishment. Secondly, the turning point of the case—i.e., the beginning of the entrance of unconscious material into consciousness—came with the interpretation to the boy that he was afraid of his father because he cherished jealous and hostile wishes against him. The boy's realization that the father knew and yet was not angry allowed him to produce his unconscious thoughts and fantasies. Third, the motive for the illness—i.e., the gain the boy obtained by being ill—was that his illness allowed him to stay with his mother and thus gave him an excuse whereby he could avoid the conflict between his affection for and his hostility toward his father. This point is highly important. It often forms a marked resistance to treatment and may necessitate lengthy discussion with the child at some point during the course of treatment.

It is not fitting in a book of this type to discuss more fully the psychoanalytic treatment of phobias, since such treatment should not be undertaken except by a trained child analyst.

Adjuvant Methods: In the case reported by Kubie and in that of Little Hans, the treatment of the child proceeded easily because in each case the therapist was the boy's own father and therefore the boy knew exactly what his father's reactions toward him would be if he expressed his real feelings. Such a situation is not common. Usually the therapist himself is not sure how the child's parents are going to accept the child when he begins to be conscious of and express some of his unconscious wishes and feelings, and unless they are warned beforehand as to the handling of the child, they may react against the child's beginning freedom and so hinder progress unnecessarily.

The direct treatment of the child's anxiety is made much more difficult when the parent of the opposite sex obtains a great deal of pleasure from fondling the child and particularly from fondling one particular erogenous zone. The mother who insists on bathing her son year after year and who uses excuses such as her loneliness or her health to insist that he sleep with her is overstimulating the boy and increasing the conflict over his jealous rivalry with the father germinated by such over-

stimulation. The parent of the same sex who is overharsh and strict and cannot tolerate any aggression on the part of his son increases the boy's fear lest the father be angry about his jealous hostility. When these two situations are combined, as they sometimes are, the difficulties of the child are increased enormously. In such situations the treatment of the child's anxiety should be preceded and accompanied by treatment directed toward changing the parents' attitude toward the child.

Similarly, the direct treatment of cases of anxiety that have arisen in families where there are marital disharmonies, neurotic parents, or favoritism of siblings should be preceded and accompanied by treatment of these situations.

In Case 21, two types of treatment are necessary—environmental and direct psychotherapy for the child. There is one bad feature of this child's environment that has to be corrected at once, for a school that treats a child the way this one has treated the boy is not a fit place for a normal child, much less a child suffering from anxiety hysteria. He should be removed immediately and placed in a different school—which is easy to say but presents practical difficulties. The school system requires that children go to the school situated in their district, and the authorities are often unwilling to waive the rules. The principals of the two schools are the ones who can make the decision, and it would be desirable to discuss the matter with the principal of the school the boy has been attending, pointing out to her that the boy has become conditioned against the school while undergoing psychiatric treatment.

It will be helpful, also, to attempt to change the parents' attitude. The mother should be advised to do less babying and to relax her strict codes, which will be easier for her to do now that the father is at home permanently and can carry his share of the responsibilities.

The father should be advised to be less strict. He will be helped to become so through his confidence that the doctor is correct in maintaining that a less strict attitude will help the boy to be better behaved and will not result in his delinquency. His ability to make the change in attitude will be increased when the mother learns to baby the boy less; he will not feel the necessity to be overstrict in order to counterbalance the mother's indulgence.

Furthermore, both parents should agree on the way the patient is to be handled, getting help through discussions with the doctor. In this case there did not seem to be marital maladjustments or parental neurosis to cause adverse attitudes toward the child. When such is the case there is little value in having them discuss their differences of opinion about

the handling of the child, because the handling of the child has become a method of expression of the neurosis or marital maladjustment and cannot be changed until the neurosis or maladjustment has improved. Since the boy suffers from anxiety hysteria—a neurotic reaction pattern developed to enable him to live with his own feelings toward his parents—the reaction pattern itself will not be greatly changed by the environmental changes. Even with an entire readjustment of the environment, the anxiety hysteria would probably remain.

For this the boy preferably needs psychoanalytic therapy. Its purpose is, first, to enable the child to understand that his symptoms—fear of going to school and phobias—are not expressions of fears of real situations but are projections of his feelings toward his father and that he is afraid of these feelings; second, to give him opportunity through speech, through dramatic play, and through his relationship with the doctor to express his real feelings—hostility, love, and fear toward his father; third, through this expression to have him realize that he does not need to feel guilty or frightened about these feelings but that they are the usual feelings of the ordinary boy of his age. The purpose of the treatment is to make him conscious of his real feelings toward his father and to give him an opportunity to express them without fear and guilt. Interwoven with his feelings toward his father there will be also his sexual wishes about his mother, which are unconscious but which will appear in consciousness as he becomes more at ease with his feelings toward his father. I have already discussed the details of such treatment.

In this case, the length of treatment will not be very great since the family situation seems to be stable. Therefore, the prognosis will be good.

Psychoanalytic therapy requires that the patient be seen five times a week. If such intensive therapy is impossible, he should be treated by psychoanalytically oriented psychotherapy. For this, one interview weekly is the absolute minimum.

The principal symptoms in conversion hysteria are disturbances of the function of various organs and systems of organs. The principal defense mechanisms against the unconscious are repression and conversion.

THE SYMPTOMS OF CONVERSION HYSTERIA

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Sunday morning when she did not get her way and was scolded. Her last attack occurred after a quarrel over a belt that she had given to one sister and that was taken by another. The mother scolded her instead of the sister. Her first attack occurred just before school ended the previous spring, and altogether she has had four or five. She is a very active child and inclined not to obey.

History. The father, who is fifty years old, has been unemployed for five years and has taken over the mother's position in the home. He allows the children to have their own way and gives in more to the patient than to the others. She realizes this. The preference became most marked the previous spring. The mother, who is forty-four, works from four to nine in the morning. She is the disciplinarian. There are six children, one boy and five girls. The patient is the fifth living child. A boy, born just before the patient, died at birth. Another brother, who was born when the patient was seven, lived only four days. The only fighting in the family is between the patient and her fourteen-year-old sister. The family is very religious.

The patient was breast-fed until the age of two and a half. The mother put quinine on her nipples to wean her. She had four teeth at six months and walked at eleven months. Toilet training was rapid, for it was reported that she was dry and clean at eighteen months. When the child had an accident, she was scolded and spanked. She had measles at two and whooping cough at four.

Examinations. Her physical condition was normal. The psychologist reported an I.Q. of 92.

With the psychiatrist she was very polite. She said that she had many friends and got along well in school. She and her younger sister slept in the parents' room. She had a bad dream in which a black bear followed her. She awakened from the dream in terror, but her father looked for the bear and assured her he could not find it and she went back to sleep. She seemed to have little imagination. Each time she was asked to make a drawing, she made a balanced design.

Diagnosis. The first symptom complex that must be excluded is epilepsy. Her symptoms appear as attacks and she has a premonition that they are coming on. The attack itself might be an aura with momentary loss of consciousness at the end. The attacks resemble epilepsy in that they have a similar basis. They occur when she is angry and unable to express her anger because of fear or because she becomes too angry. A careful examination and an electroencephalogram ruled out the diagnosis of epilepsy. She apparently shows no anxiety except about the

symptom and in her fear dreams. The fact that she sleeps in the same room with the parents would certainly make her anxious, and the situation would excite and interest her sexually. Her behavior traits of politeness, lack of initiative and imagination, stubbornness, and good schoolwork are all developed for the purpose of avoiding any situation that might induce an emotional reaction that might frighten her. These apparent virtues are really defenses against her being her spontaneous self and indicate that she has much unconscious anxiety, part of which is being converted into hysterical symptoms, i.e., the sensation in the tongue and throat. The diagnosis would be conversion hysteria.

Psychopathology. When we look at the history we see many sources for anxiety. She had a long period of breast feeding terminating in an unpleasant weaning. Her toilet training was very severe. There was a marked parental preference for the older sister. The mother's prudishness would cause her to suppress any sexual interest. The fact that she slept in the same room with the parents would not only make her anxious, but would make her feel hostile and antagonistic toward the mother. This hostility and jealousy would be increased by the father's preference, which seemed to have increased suddenly the previous spring for reasons I do not know, and by the fact that he allowed her to get into bed with him when they were alone in the house.

The child of such a severe mother would be afraid to express openly the hostility and jealousy toward the mother engendered by the father's preference for her and therefore would have to repress much of it. Some of the hostility was directed toward a mother substitute—her older sister—but this expression of jealousy got her into trouble both with the mother and with the older sister. The child was ill, therefore, because she had a conflict between her love and desire for her mother's love and her hostility toward her. She tried to solve the conflict in two ways. The tongue and throat symptoms were the signs of her oral dependence on the mother, and her behavior was an attempt to avoid any situation that produced her feelings of hostility.

Treatment. In this case adequate treatment will have two directions—a change in the impossible home situation and a change in the girl's attitude toward her unconscious feelings and ideas. First, the patient must cease to sleep in the parents' bedroom. The father should be made to see that too close physical contact with his daughter is not good for her. The mother should be encouraged to be less prudish and punitive toward the child's behavior. If possible, her favoritism toward the older sister should cease. In a home like this, where there are so many adverse

factors, it would be advisable to spend a long time, perhaps a year, in endeavoring to get the familial emotional situations straightened out. If this does not result in great improvement in the child, then direct, intensive psychotherapy will be necessary. The goal of treatment will be to help the girl to verbalize her conscious sexual and hostile feelings and to bring into consciousness similar feelings of which she is unconscious because they have been repressed.

I have presented this first case to illustrate what I mean by a conversion symptom—i.e., a disturbance in an organ or a function. Since conversion hysteria is an important and common syndrome in childhood, I will present a second case to illustrate the psychopathology more clearly, and by a very full presentation of a third case will endeavor to show how the psychodynamics of the condition are ascertained during treatment.

THE PSYCHOPATHOLOGY OF CONVERSION HYSTERIA

CASE 27. A boy aged nine is referred because he has had a trancelike attack, has a reading disability, and until very recently had enuresis.

About a week before referral he awoke in the morning with a headache and sore throat. He stayed home from school, and at two o'clock in the afternoon his mother found him in a trancelike state with his eyes wide and staring. Upon being awakened, his first words were, "I can hear you, mother, but I can't see you." He later told a doctor that he was chased by a ghost.

His enuresis began when he was six years old. At that time he had had a severe shock when he came home to find his father dead. Since then he has been very nervous, has had enuresis, and has lost weight. He seems to be afraid to go to the bathroom to defecate and usually moves his bowels before getting there. This has become more marked during the past year and started following his circumcision at the age of four.

He is almost unable to read, although he has been in school three years. He is in the second grade and is failing. The psychologist reported that the result of the revised Stanford-Binet test indicated that the patient had dull normal intelligence. His effort is poor and he is easily discouraged. Reading tests are very poorly done, and although it is impossible to complete them because of his restlessness, the incomplete results suggest a serious eye deficiency as well as a poor foundation in reading readiness. The psychologist suggested that he have an ex-

amination for visual acuity and that since his reading level is that of a child beginning first grade, he should learn to read from the beginning with a special tutor.

History. He was the first child of a nineteen-year-old mother who was unable to care for him, so he was adopted at the age of ten days. In his adoptive home were two foster siblings—a boy now aged seventeen and a girl thirteen—with whom he slept. He was very much attached to his foster father, who died accidentally when the patient was six years old. He was greatly affected by this. About a year after her husband's death, the mother went into a convent and the children were put in boarding school. Both mother and children, particularly the patient, worried so much about one another that after ten weeks she decided to make a new home for them. She had to work to do this. Since the return from the separation, the adoptive mother had to impress upon the patient that they would not be separated again. Recently she thought that he was now beginning to overcome some of his fears of losing her.

His birth was normal. Although he was not breast-fed, he had excellent care during his first year of life. He gained well, slept well, was not fussy about food, and had no vomiting or any type of feeding problem. He was very friendly and likable. His mother believed she had babied him more than her other two children, who felt that the boy had his mother wrapped around his little finger. He crawled, sat up alone, and got his first tooth at the age of eight months, and walked at ten or eleven months. His bowel and bladder training was not begun too early and was not severe. He was circumcised at the age of four because the mother thought that his phimosis was making him handle his penis a great deal and that he would stop if circumcised. The handling of his penis was his normal masturbation. He was very frightened during his hospitalization and has since been afraid of hospitals. He did not handle his penis after he returned home. He had an appendectomy at the age of nine.

Examinations. He had no organic disabilities except his defective vision.

I have already reported the results of his psychological examinations.

He told the psychiatrist that he did good schoolwork. He admitted he had a reading difficulty and said this was because reading was hard to learn. He felt he could see better without his glasses and therefore he was sure he had no eye trouble. He denied having fears but said he developed a pain in his stomach whenever he hit his brother or sister.

He expressed devout religious tendencies. He wanted to be a priest when he grew up.

Diagnosis. The description of the trancelike attack indicated that the patient had an attack of hysterical blindness. It is difficult to be certain whether this was true hysterical blindness or whether the patient had a hysterical fugue, i.e., a hysterical trance state. The latter seemed probable since he could hear but could not see. His bowels moved three times a day, which was more often than necessary and showed increased peristalsis. The trance state, the enuresis, and the bowel condition were all symptoms of conversion hysteria; that is, he was attempting to deny his feelings of anxiety by converting them into physical symptoms. Also, he denied his real difficulties—his eye defect, his poor schoolwork, and his fears. He was willing to admit his reading difficulty but excused it on the basis that reading was hard to learn. He denied these difficulties because if he admitted them he would feel very anxious and frightened. The mechanism of denial is also typical of conversion hysteria. Through the use of this mechanism the patient has little if any conscious feeling of anxiety and so feels comparatively comfortable.

Psychopathology. The boy's main psychological defense of denial and conversion was for the purpose of avoiding feelings of guilt and anxiety. His feelings of guilt were indicated by his deep religiousness and by his desire to be a priest. The presence of feelings of anxiety was indicated by his reaction to his visual defect. He stated something that was manifestly untrue: that he could see better without glasses. This reaction indicated that he was afraid to admit there was something wrong with him physically. His mother was very antagonistic to his infantile masturbation and had him circumcised in order to stop it. From his point of view, through the circumcision he had lost part of his genitals and the thought frightened him greatly. The fear was so great that he had to repress it, but the thought of any physical defect, such as his visual difficulty, had to be denied lest the fear return from repression and overwhelm him. He had a further reason for his fear. If he had already been punished by a partial mutilation, he might be punished again but more severely by the loss of the rest of his penis. He could not consciously tolerate any such ideas about his penis—the most important part of his body—so unconsciously he displaced them to other parts of his body. They appeared in the trance—he could not see or speak; i.e., he had been blinded and his tongue had been cut out. He suffered from typical castration fears.

If he felt in danger of punishment by castration, what were his crimes that would put him in such danger? He regarded his circumcision as a punishment for the act of touching his penis, which he thought was wicked. He was very frightened by the operative experience, so frightened that afterward he could not admit to a defect in his eyes. His fear also forced him to give up the act or at least to make many attempts to do so. As a result of his fear, he repressed his desire to masturbate and regressed from the level of phallic sexuality to the anal-sadistic level. From this time forward, whenever he became sexually excited, he tended to have increased uncontrollable action of his bowels and to soil himself. This soiling accomplished four purposes:

1. He obtained relief from his desire to masturbate by using the more infantile anal method of getting gratification by moving his bowels.
2. He denied being responsible for gratifying his sexual feelings, rationalizing that his bowel activity was independent of his will.
3. He punished himself for his sexual gratification through the discomfort and shame of soiling.
4. He obtained additional intrapsychic pleasure from his mother, who had to clean him after the soiling and in so doing could not fail to touch his genitals.

His desire, which he thought was wicked and for which he thought he would be punished by the loss of his entire penis, was to touch his penis—an act universally done by children of his age whenever they are stimulated by their own sexual desires or by their environment. His sexual feelings were being stimulated from two sources:

1. He slept with his sister. For a boy of nine, just entering adolescence, to sleep in the same bed with a sister and have at least partial contact with her body would be very stimulating sexually. Being stimulated sexually in this way, he would feel the need of relief of the sexual tension. He could get such relief from having intercourse with her but he knew that to do so would be considered a great sin, for which he would be punished by the loss of his penis. He could get relief from masturbation but feared to do so lest he be punished in the same way. He probably sought some relief by handling his penis without carrying the handling to the point of orgasm. Instead of giving him relief, this would only excite him more.

2. He was stimulated sexually by his mother, to whom he was very much attached. She had to clean him after the bowel accidents, which would stimulate but not relieve him. He received his mother's attention when he was ill, but he wanted attention of a more intimate kind than

she could give. He had to defend himself against this desire by being unable to talk to her or to see her.

One of his main sins, then, consisted of his overstimulated sexual feelings, of which he dreaded to be conscious lest he be punished.

His second sin was jealousy and aggressive feelings toward his siblings and his father. He said he got a pain in his stomach whenever he hit his brother or sister. He also had an abnormal fear of being hit; i.e., when *he* hit someone, he wished to hurt badly, so he was afraid other people would want to hurt him badly when they hit him. In his trance, he had the idea that a ghost was chasing him and so was unable to speak to his mother or see her. Also, after his father's death he developed enuresis, another anal-regressive expression of sexual desire. These facts indicated that although he liked his father a great deal, he was very jealous of him. The ghost was the dead father and the trance said that if the father should return, the patient must not see or speak to his mother. It was obvious that when the patient's father was alive he wished him dead so that he could possess the mother himself but did not want his father to know of this wish. When the father did die, his wish came true and he became very frightened and guilty about having had it. Therefore, he regarded such wishes and feelings as wicked and punished himself for them by a sense of guilt. He also tried to make reparation for them by implying that he wished his older brother to be the father in the family.

There is an additional reason for his dreading both his sexual and his jealous wishes: the mother had been strict in her training and had impressed him with the fact that both groups of impulses were wrong and offensive to her.

As a result of these situations, the boy had come to regard any feeling or expression of feeling of sexual or aggressive desires as dangerous and wicked, and to avoid his feelings of guilt and fear had begun to inhibit his activities, to alter his physiological functions, and to plan his life—e.g., his desire to be a priest—so that he would not be aware of having either sexual or aggressive desires.

Treatment. The main aim of treatment will be to remove the fear and guilt he feels about his sexual and aggressive impulses. This can be accomplished in two ways:

First, certain environmental changes should be made.

1. He should sleep by himself in a room by himself. This will remove the constant sexual stimulation of sleeping with his sister.
2. His mother's oversevere standards should be altered to permit the expression of normal childish impulses.

3. The boy should have more opportunity to associate with men, and thus learn about masculine reactions.

Second, he should have direct intensive psychotherapy for his feelings of fear and guilt regarding his sexual and aggressive impulses. Since his father is dead and since such an event is a severe traumatic experience to any boy, treatment will be more prolonged than would be the case where such a traumatic event had not occurred.

THE PSYCHODYNAMICS OF CONVERSION HYSTERIA

How the psychodynamics of a case of conversion hysteria are elicited during therapy is illustrated by the next case.

CASE 28. A girl of eleven was admitted to the hospital ward with an acute attack of abdominal pain—most severe in the lower right quadrant—vomiting, and constipation.

Her physical examination on admission showed the following signs. She was a thin, pallid youngster, weight 68 pounds and height 59 inches. She had a pulse rate of 98, a respiratory rate of 20, and a blood pressure of 115/65. Her eyes, ears, nose and throat, mouth, chest, lungs and heart, skin, bones, joints, glands, and nervous system were all normal. Her abdomen was flat. There was no muscular rigidity. The descending colon could be rolled under the finger and was tender. There was tenderness on palpation over McBurney's point. In the right lower quadrant an indefinite, tense, clump-shaped mass could be felt. Neither liver nor spleen was palpable. On rectal palpation a definite tenderness and a vague swelling in the right side of the pelvis were found.

Repeated blood counts were normal except once. Repeated urinalyses were normal. Blood Wassermann, tuberculin tests, and sedimentation index were normal. X-rays of the heart and lungs and of the gastrointestinal tract by means of an opaque meal and a barium enema showed them to be normal.

During her stay in the hospital, the attacks of pain became less severe. On one occasion she had quite a severe one, accompanied by vomiting, that started in the middle of the night but was gone completely by the next morning. The vague mass in the lower right quadrant of the abdomen disappeared and reappeared on several occasions. When she was discharged from the hospital, the pediatrician stated that the only organic abnormality he could find was a moderate degree of malnutrition.

This was not the first attack. Similar attacks had occurred every two or three months for the last four years. The child's earliest history was

not known. When she was five years old she had a tonsillectomy and adenoidectomy. Shortly afterward, she was examined because she seemed short of breath. A diagnosis of valvular disease of the heart was made and she was placed on a routine of restricted activity. (During her stay in the hospital a thorough cardiac examination, including an electrocardiogram, showed no evidence of a cardiac lesion.) She had enuresis, for which she was seen once in the clinic when she was nine years old. Only one interview was permitted by the parents. At that time she stated that she could never marry because of a heart lesion which she felt she had contracted because at the age of five she picked up and ate dirty things in the street.

History. Her father was a rather handsome man who had made a very poor social and work adjustment and who was a crank about food and physical culture. He was partially impotent. There were constant quarrels with the wife, whom he deserted frequently. He was an immature person who felt very inferior, for which he had compensated by marrying a dwarf; nevertheless he felt inferior to her and acted toward her as a child to a mother.

The patient's mother was an achondroplastic dwarf, quite conscious of her physical inferiority, for which she compensated by marrying a comparatively handsome man and further tried to compensate through her sexual desires. Since the husband could not satisfy her sexually, there was constant nagging and quarreling. The patient was the elder of two sisters.

Examinations. The patient was a very prim, polite, earnest child who gave the impression of being a little old woman. She had an I.Q. of 101 and on tests her social maturity was approximately average. She was diagnosed as suffering from conversion hysteria and taken for psychiatric treatment. Before this was done, however, she was placed in a foster home, since it was felt that her own home did not offer a satisfactory environment for a child.

Treatment. At first, in psychiatric treatment she denied any discomfort or unpleasantness in her relations with her own family. She was unconscious of any feelings of hostility toward her mother, or of any feelings of jealousy toward her sister (who was very much the mother's favorite). She felt such feelings were wicked and no proper little girl could ever have them.

Early in the interviews one thing became apparent—that she could never show any anger toward her mother without having terrific guilt feelings. It was always necessary for her to apologize to her. However,

she said that she could show anger toward her father without feeling badly about it. She early recounted some anxiety dreams, one concerning a woman with very long finger nails being very cruel to a boy. It was apparent that she fled from her fear of her hostile feelings toward her mother by identifying herself with her father, for after one of the interviews she said she had had a dream in which she was with her father, who told her he had been to a nerve doctor who had told him he must not let himself get nervous and thus become angry and hit his wife (her mother). In reply she told him he should pay attention to what the doctor said and so not lose his temper and hit her mother.

She was afraid consciously that if she disobeyed her mother—i.e., showed any feelings which her mother might characterize as rebellious—she would die or would lose her mother's love. In connection with another dream she said, "I just had to do what mother said, for I thought I'd die. They always used to say if I ran about too much my heart would break or tear." In continuing this discussion about her mother, she said, "Everybody used to say if I weren't careful, and jumped, I'd die." Sometimes when the mother was angry she would say to the child that if her parents were divorced, she would have to go with the father rather than stay with her mother. "She said that when she was angry." "Sometimes I feel like crying. Sometimes she made me feel like I was hurting her. I think she was saying that to make me understand." "She used to tell me that no matter how much she yelled at me she still loved me." I asked her whether, if she had a daughter, she would yell at her and say such things to her, even though angry, and she answered, "I don't think I would." Then she said, "My father tried to tell me not to mind what my mother said because she only said these things because she was angry."

She was asked whether she had wondered if her father loved her when he left home so often. "Oh, I always knew he loved me, but he left because he and my mother were quarreling." I asked her if her mother was responsible for her father's leaving, and she said, "He used to be a little bother about the house," but then went on to say that no sooner was he gone than her mother started missing him and wanted him back again.

Fearing so greatly to lose the mother's love, she had made it a point to observe what attitudes or behavior would insure her certainty of it. These she found in illness. I asked her to tell me when she was most certain of her mother's love, and she said, "When I used to be sick,

she talked to me and cheered me up—she was cheerful, called up my friends, used to do everything to cheer me up.”

“Then when you were sick, you were sure she loved you?”

“Yes.”

“Then when you got well, she’d start yelling again?”

“Yes.”

She said she had been home from camp only a few days when her mother commenced yelling at her. She said to her mother, “Look, Mother, I just came home. Don’t holler at me when I’ve just come home.” She said she used to be happy when she could run around a bit, that she would sneak out when her mother was not looking and would run and jump rope. However, the neighbors would see her and say that she didn’t take care of herself and would tell her mother they did not think she would ever get fat because she exercised so much.

Her fear of losing the mother’s love was the conscious representation of a feeling of guilt regarding her hostility toward her and her desire to disobey. She said she felt guilty “maybe because I caused trouble. I had to be sick or I made out I was sick.” She felt that her illness was responsible for her parents’ quarreling and unhappiness. They worried about her. Now when she saw them they were cheerful, nicely dressed, “as though everything [at home] was perfect,” so it might be better “even though I wasn’t home for a couple of years.” She wondered why home could not be peaceful, cheerful, and nice while she was there. At this point I told her I thought she felt guilty about feeling happy where she was because she did not miss her mother more than she did. She perhaps felt that she should not be having so many material comforts when the others in her family did not have them. She partly admitted this to be true. I then told her that she was not responsible for her home situation, that it was her parents’ fault that they could not get along with each other and that they were the ones who were guilty for the quarreling between them. I told her that since she was not to blame for the home situation, she was to enjoy herself now, that each person had to live his own life, that she could not live at home because of the discord, that she now had a place in which she could be happy, and that she should stay where she was until she had got to the point where she could go home without being affected by the quarreling there. She then spontaneously told me that it upset her to come into the house and hear her father and mother quarreling. She did not like it because it was “savage,” and when they quarreled she wanted to go out and forget. She tried to calm her mother down, for she might get her father

so angry as to make him hit her, and then he might be taken by the police, as happened once, or her uncles who lived near by might come, as they once did, and beat him with baseball bats. On that occasion she was greatly upset, everyone knew about it, and she was embarrassed. Whenever they fought, she remembered the incident. We talked about her guilt feelings about her family.

After her guilt about her hostile feelings toward the mother was relieved, she was able to discuss the mean and unloving ways her mother treated her (which was true), her longing for her mother to love her, her resentment because she did not, and her wish that her mother would go away and leave her with her father. At this time, however, she displaced her guilt feelings because of her hostility toward her sister and mother onto the foster siblings and mother, saying she was the cause of the siblings' bad behavior.

Her ambivalence toward the foster mother became evident. Once the foster mother made chicken salad. "It was very good but she put onions in it. I told her I didn't like it. Later she made some more and I asked her for some. She told me that I had told her I did not like onions, so she had saved a share of the chicken and not made salad with it. Now I was asking for salad. She felt that she did not understand me and sometimes I don't understand myself."

Although she began to love her foster mother a great deal and had tried to be like her, unconsciously she still felt hostile, repressing the feeling because she felt that she would be punished for it by death. In order to avoid the punishment, she unconsciously identified herself with her dead aunt. One night there was a towel over the foot of the bed and she began to imagine it was a dead person or a ghost. She imagined that she had called her foster mother to her room and that the creature had bitten her and that she had fainted. Then she imagined the creature was the ghost of her aunt, who in life had been crippled and had had heart trouble. She also was small, like the patient. She had been very unhappy but had really loved the patient and her sister. One night the aunt went down into the cellar and drank almost a bottle of poison, and her husband found her dead. I asked her if she had ever thought of committing suicide, and she replied, "When I was at home I did. I used to be very unhappy. I told my mother I was going to commit suicide, but even my father said that was bad." When she was younger, she used to think a great deal about ghosts. Once she saw a movie about a werewolf and felt frightened for the next year whenever she thought of it.

Later through this fantasy she became conscious of her hostile desire to bite her foster mother but felt that the desire was so bad that she ought to kill herself as her aunt did.

Her feeling of guilt made her feel different from other people. "I was always afraid or ashamed to talk. I felt I wasn't anything to anybody. I thought everybody thought I was useless because I had a weak heart." She realized that she always tried to be exactly what somebody else wished her to be. "The nice girls didn't talk to me, only the stupid ones. I say 'I'm fine' so other people will be glad I'm getting better." She felt guilty for saying she felt well when she really did not. She did this because she imagined other people always were well.

In order to avoid her guilt feelings she attempted to deal with her hostilities by identifying with her father—in this case with the foster father. "He's not a very nice man. He doesn't talk to Mrs. M.'s mother. He thinks people steal his ties. It's just since the baby came he's acted like that. He says till I can act nice to other people I can't expect them to act nice to me. Yesterday when he came home I didn't speak to him." Her own mother's statements had prepared the way for this identification with the father, for when angry "she would say I took after my father and that she didn't love me because I took after my father."

As a method of compensating for her feelings of guilt, she had a strong desire to be loved and comforted, particularly by the foster mother. She had to be reminded when bedtime came. This embarrassed her. She discussed her unwillingness to go to bed when the foster parents had guests. "Mrs. M. has some nice friends. I want them to see me and like me." She said she wanted her foster father's friends to see her and think she was nice so that they would tell her foster mother what a nice girl she was. She also was afraid they would wait to have ice cream until after she had gone upstairs. She said that she got mad at the foster mother when she yelled at her but that she did not get mad at her own mother. She always had to make up with her mother right away, whether she was right or wrong. She said, "I thought it was not right for a child to get mad at her father and mother." If she got mad at them, they would not like her, she would have to go away and she would have no father and mother to stay with when she got older. She said that when her mother became angry "she would say that she didn't love me because I took after my father. When you grow up, you'll go away with him and live with his family in New York. Then you won't have a mother to clean up for you." "Sometimes my

mother used to tell me she was going to send me away where I would not see them for a long time." "I really realize my mother was all wrong in telling me these things." She told me about a widow who was always "hollering" at her fourteen-year-old daughter. "I think a mother like that sometimes deserves to be killed." I asked her if she had ever thought she'd like to kill her mother. She said no but repeated that a woman like that deserved to be killed. However, "Normal children do not hate their parents." Following this she began to talk about her dislike of the foster siblings—particularly of the baby. Soon she began to remember her hatred of her own sister and her death wishes toward her.

The hostility toward the foster mother which replaced that felt earlier toward her own mother came partly from her sexual attraction to the foster father. "When Mr. M. talks to me in a friendly way, I choke up and can't talk right." This choking up was the result of her feelings of guilt about her fondness for her foster father because it aroused hostility toward her foster mother. At this point the interviews began to concern themselves with the history of her sexual life. In reply to a question, she said she had seen her father nude but had never wondered about the difference or why he slept with her mother. Sometimes she liked to sleep with her mother. Once all four members of the family were lying on the bed and she wondered why her father wanted to lie next to her mother and not next to her. She knew where babies came from because she had seen the foster mother during pregnancy. However, she was afraid to think about pregnancy or even to listen to talk about it. "It seemed kind of frightening and you could die or something. Sometimes when women have children they die of it and I might, and I want a nice family." After she had thoroughly discussed the subject of pregnancy, the subject of masturbation was broached to her. She said she and her sister used to play with themselves and with each other, sometimes using a spoon. Her mother had caught them in the act and had told them to stop because if they continued they would not be nice girls when they grew up and the act would surely kill them. So because of the threat, they had stopped. In relating this, she was freer in her expression of hostility toward the mother.

I asked her what she meant by a girl who was not nice. It was one who became pregnant without being married, and even as a little girl she had known this. I discussed with her the possibility of a connection in her mind between her ideas of pregnancy and her attacks of abdominal

pain. She then said that after she stopped masturbating she had indulged in sex play with some boys and that she had been afraid that her parents might find out and also that she might become pregnant. Her fear became so great that she stopped the sex play.

When her guilt and her fear that she would die because of her sexual behavior were relieved, she discussed her desire to separate her parents and to get rid of the mother and was able to talk more freely about her jealousy of her sister. The psychic release produced in this way enabled her to discuss at considerable length her own masturbation and the mutual masturbation that had taken place with her sister and for which she had been threatened with the statement that she would not grow up if she continued. This episode occurred just before her shortness of breath began. When she learned she had a heart lesion, she believed she had injured her heart and herself for life, and was very frightened and anxious. Anxiety had produced the shortness of breath, and the ideas associated with it had formed the basis for the rather bizarre statement she made when she was nine, that she had produced her heart condition by eating dirty things on the street. It should be noticed that she had strong oral sexual fantasies. It will be recalled that she said she choked up when her foster father talked to her in a friendly manner. This symptom was based on an oral idea of intercourse. Although the material was not completely uncovered, it developed that during the mutual masturbation with a spoon, the spoon later was sucked. She never could get married because of the heart lesion, and by not marrying she could not have sex desires and would be a nice girl. She stopped masturbating and then engaged in sex play with some boys, whereupon she became so afraid that she stopped the sex play. Her abdominal symptoms began about this time.

This material was produced during a long period of psychiatric treatment. She had her last attack of abdominal pain toward the end of the first half of treatment and has had none since, although treatment has been stopped for several years. Her primness and old-maidishness have disappeared. She has a healthy relationship with her foster parents and a healthy interest in boys. Physically she seems a different person.

Psychodynamics. The material presented indicates that the girl's character reactions of primness, old-maidishness, and propriety and the disturbances of the lower intestinal tract and of the heart were the end results of her attempt to banish from consciousness the memories of certain sexual experiences, any sexual and aggressive feelings, and the realization that the latter were directed largely toward her mother and sister. As we

trace the physical symptoms we find that they contain the following group of impulses:

1. She used the abdominal symptoms to obtain love from her mother. Having found that her mother, who was seldom kind to her, was kinder when she was ill, she developed the habit of wishing to be ill whenever she wished her mother to love her.

2. The need for assurance of her mother's love was overstimulated by the constant quarreling between the parents and by the mother's frequently repeated statements that the child could go with the father whenever he deserted them.

3. Since she wanted her mother's love, she had to repress her hostility toward her mother. The repressed hostility appeared as a feeling of guilt and as the painfulness of the abdominal symptoms; i.e., the pain was a punishment.

4. The hostility toward the mother was based on the normal sexual attachment of the child to her father and the resulting jealousy of the mother.

5. She tried to avoid the feeling of sexual attachment to the father by feeling irritated with him, by identifying with him, and by fantasizing about him—the fantasies appearing in her symptoms. The lack of appetite also was an attempt to reject her attachment to the father, since he was insistent on diets, which insistence annoyed the mother.

6. The hostility toward the mother also expressed itself as a desire to disobey her. We have seen that in the child's mind, disobedience was associated with her sexual feelings toward the father; i.e., it was associated with sexual acts. These were (a) sexual relations with the sister, and (b) sexual relations with boys. The relation of these to the symptoms must be discussed separately. The mother would not permit her to express any jealous hostility either toward her younger sister or toward herself. So to please the mother she had to repress the hostility she felt toward the sister and attempt to overlove her. She was able to do so only through the sex play, which was an erotic act but also contained elements of hostility, since she knew that if her sister were caught in the act she would be punished by both parents. Afraid lest she be caught, afraid also of displeasing the mother by making her younger sister do bad things, she stopped the sex play. The erotic satisfaction she obtained could not be given up so easily, and she seemed for a while to have been tormented by a desire to continue the act. The attempt to repress this desire from consciousness was successful, but the awakened desire remained present and gave her a conscious feeling of anxiety and

discomfort. The conflict of desire and fear so affected her heart rate that she was taken for examination and told she had a heart lesion, which was not the case. As a result, she came face to face with an intimidating situation. She had been a bad girl, had done bad things to and with her sister, i.e., the eating of dirty things. As a result, she had injured herself permanently—by her heart lesion—and could never be sexually competent—i.e., she could not get married. Henceforth, whenever she had a sexual impulse, the real feeling remained unconscious but was felt as a conscious feeling of guilt which was so uncomfortable that she tried to avoid any small misdemeanor that might increase it.

After a little while she got over the fear of oral sexuality and was able to allow herself sexual feelings toward boys. Here again her dread lest the mother find out and leave her became so great that she stopped the behavior and repressed the desire from consciousness. Its activity in the unconscious caused a feeling of guilt and she began again to feel that there was something wrong with her body. She displaced the feeling in her body from the genitals to the abdominal tract and changed the feeling of pleasure to one of pain. The abdominal pain, vomiting, and constipation represented fantasies (which she kept unconscious) of sexual relations, marriage, and childbearing, procedures which girls of her age usually think of consciously but which, because she felt so guilty, she had to keep unconscious.

It was fortunate for this little girl that she came into the hands of a wise pediatrician who was not obsessed with the desire to take out her appendix but who recognized the case as one of conversion hysteria and referred her for adequate psychotherapy, not of the intensity of psychoanalysis but conducted along analytic lines.

CONVERSION HYSTERIA (*Continued*)

PREGENITAL CONVERSION HYSTERIA

THE SYMPTOMS of conversion hysteria occur in the form of disturbances of physiological functions of repressed instinctual wishes of the phallic stage of development. The patient, in order to solve his oedipal conflicts, regresses to the phallic stage, through which he just passed. The symptoms of an obsessional neurosis occur in the form of disturbances of the mental activity of repressed instinctual wishes of the anal-sadistic stage of development. Again, in order to solve his oedipal conflicts the patient regresses deeply to the stage of development that precedes the phallic. Since the instinctual wishes of the anal-sadistic stage are re-activated by this regression and endeavor to break through into consciousness and action, a secondary conflict rages around them which causes them to appear in a very distorted form. These distorted wishes contribute to the symptomatology. There is a third type of neurosis whose symptoms occur in the form of disturbances of physiological functions of repressed instinctual wishes; i.e., they are conversion symptoms, but the repressed instinctual wishes are not those of the phallic stages but arise from much earlier stages of development. A high degree of regression has occurred also, so that the mental activity resembles that of the obsessional neurotic. In such patients the physical symptomatology is of the nature of a conversion, while the organization of the mental life corresponds to that of an obsessional neurotic. Hence the name "pregenital conversion hysteria." The most common syndromes of pregenital conversion hysteria are stuttering, psychogenic tic, and bronchial asthma.

The following case of pregenital conversion hysteria shows at least two of these conditions.

CASE 29. A boy of thirteen is referred because of severe stuttering. He is afraid of thunderstorms and has nightmares, which are less frequent now. Since the age of eight he has suffered from asthma, which has interfered with his school attendance. He does not do well in sports and is timid in new situations. He does not make friends readily because he is aloof and reticent, inclined to keep his thoughts and particularly his feelings to himself. However, he has a tendency to be outspoken about certain political and social ideas. He does moderately good schoolwork, being very interested in reading and in mechanical pursuits; he is particularly interested in guns, of which he possesses quite a collection.

History. He was the only child of his parents' first marriage. His mother was well during the pregnancy. The birth was prolonged, and he was delivered by instruments. He was breast-fed for two weeks only. He suffered from an enlargement of the thymus, for which he was treated by X-rays. He sucked his fingers until he was two and a half years old, his parents objecting to the habit and finally stopping it by the use of thumb guards. His bowel training was completed by the time he was one year old, at which time, also, he was dry in the daytime. His bedwetting ceased at one and a half.

During the early years of his life his mother did not show him much attention because his father did not want the boy spoiled. As a result, it may be said his mother neglected him and turned him over to the care of nurses. His first nurse was dismissed when he was two years old because she masturbated him. At the age of two he had pneumonia, following which he was usually irritable and peevish when he awoke from his nap. His stuttering started when he was about three years old, at which time also he objected to having his hair and nails cut because of fear. When he was four his parents separated because of incompatibility. The boy was not told about the approaching separation but was presented with the fact when his mother brought him from her summer home and left him at his father's new residence. Here he lived with his father and a housekeeper who had a violent temper and who frequently slapped him. He spent the summer months with his mother. The violent-tempered housekeeper was discharged and replaced by a nurse of whom he became so fond that when he was five his father discharged her. The boy was greatly upset. At the age of five he started school. His asthma started at six after a walk with his father. He felt tired and wanted his father to carry him, but the father refused. The

father remarried when the patient was seven, and the mother when he was ten. When he was eleven, his father had a daughter. He liked his stepmother and expressed no objection either to his father's remarriage or his mother's or to his stepfather, nor did he ever ask any questions about the original divorce. It was as if he took all these changes for granted. When he was nine years old, he spent the winter with his mother in Florida, and there he developed daydreams of a masochistic nature; i.e., he experienced sensual pleasure by being made to suffer pain. In these daydreams—which were the same as his later adolescent masturbation fantasies—he was tied down in an uncomfortable position by a man at a woman's behest while the woman gloated over him. At the outbreak of the war, his father enlisted and the boy went to live with his mother.

Examinations. Physically he was tall and slender. He had no physical disorders except a tendency toward asthmatic attacks. His tongue, mouth, and throat were normal. He showed no signs of aphasia. His intelligence was above average, and his school placement was in accord with his intelligence.

Psychopathology. There is not space here to permit presentation of the complete data from which a knowledge of the intrapsychic conflicts in this case was obtained, and so I am going to present simply the salient features. The patient was passively dependent on his father and felt that he was incapable of growing up or supporting himself or marrying. Consciously he preferred the father to the mother. He could not remember feeling any anger or hostility toward the father and could not imagine such feelings. In order to maintain his passive-dependent attitude, he repressed his hostility. He had a great fear of any hostile feelings toward the mother and felt himself unable to express even the least independence. As I mentioned earlier, his masturbation fantasies were all passive-submissive, exhibitionistic ones. This passive-submissive attitude gave him a homosexual orientation of which he was unaware except that he seemed to be more diffident with girls than his friends were.

Underlying this passive-submissive attitude were marked anal sadomasochistic drives—i.e., unconscious desires to obtain sensual pleasure from hurting other people and being hurt by them. He felt strongly anal-sadistic toward women and girls—his sexual fantasies were of murderous and cruel attacks on women, particularly on their buttocks—and masochistic toward men and boys—he had one fantasy that a brave boy would die and in consequence the boy's father would die

with horror. These fantasies and the horror engendered by them caused him to act weakly and dependently. Behind these sado-masochistic drives lay his great loneliness and longing for his mother, his spitefulness at her treatment of him, and his hostility toward his father because the latter took him from his mother. His feelings about his parents' separation and the way he had been treated by them were pathetic in their agony when he remembered them.

Often when he stuttered he made a kissing or sucking sound with his mouth. When this was brought to his attention, he was horrified, having believed that any boy who thought of kissing a girl was perverted. His stuttering represented a conflict between his desire to kiss and suck and his conscious ideas that such activities if directed toward a girl were abnormal. This conflict—of which only the ideas of repudiation were conscious—was a representation of a completely unconscious conflict. In his unconscious he desired to kiss his mother and to suck her breasts. He was very interested in women's breasts. He kept these desires repressed because he feared that if he admitted them, his father would be angry and repudiate him, and his mother not only would refuse him the gratification he desired but would consider him even more unworthy. The stuttering, therefore, represented his longing for the mother, couched in oral terms—of which desire he was unconscious when he first came to treatment. His asthma expressed his desire to ask to be picked up, carried, and looked after—consciously by the father but unconsciously by the mother.

As he became more conscious of his embarrassment about his stuttering, he insisted that it was not that the stuttering embarrassed him but that he feared its effect on his auditors: it would make them very unhappy and ashamed. He complained also that it interfered with his desire to be acclaimed and respected by his colleagues and teachers in school and that he lost prestige and marks because of his difficulties in reciting. However, he felt also that only abnormal people wanted to show off. His stuttering, therefore, represented two other unconscious conflicts. The first of these was a conflict between his desire to be exhibitionistic—i.e., his unconscious desire to get sensual pleasure from being looked at—and his repudiation of such a desire. As a small child he had been exhibitionistic to a marked degree during the anal-sadistic stage. Once he felt great pride in moving his bowels on the front steps of the house—for which he was punished. His exhibitionism, therefore, had a strong anal element and in his unconscious represented the passing of flatus, which indicated that there had been a regression from the desire to

exhibit his penis during the phallic stage to the desire to exhibit flatus and feces during the anal-sadistic stage. There were many reasons for this regression, but outstanding was the fact that he felt very humiliated because he had been circumcised while his father had not. In his unconscious he felt that one of the reasons why his mother was not interested in him and had left him with his father was that she felt he was an inferior person and not worthy of love because he was circumcised.

His heterosexual desires (which originally had been directed toward the mother as their object) had therefore regressed to those of the oral and anal-sadistic levels of development. His sexual fantasies about girls were consciously anal-sadistic: he had had to repress his phallic desires and regress to anal-sadistic ideas of making love and obtaining sexual gratification.

The second unconscious conflict that expressed itself in his stuttering lay between his hostile feelings (namely, toward his father) and the fear that if he expressed them he would lose the father's support and protection, as he formerly had lost that of his mother. His speech would humiliate and shame his auditors. The things he would like to say to the father to express his bitter hatred because he had so consistently interfered in his love relationship with his mother and the mother substitutes would hurt, humiliate, and destroy him. He could express this feeling very indirectly in his stuttering by drawing the attention of his audience to what an incapable person he—the son of his father—was. Here again the hostility was not that of the phallic stage but that which would be expressed by the use of flatus and feces during the anal-sadistic stage. Instead of the conflict being worked out in disorders of function of the lower bowel, it had become displaced to a disturbance of one of the functions of the upper end of the gastrointestinal tract—the function of speech.

In short, his asthma and stuttering were an expression of his conflict between his uncertainty about his parents' love—particularly his mother's—and his bitter resentment of the way he had been treated. His speech difficulty was itself a conflict between a wail for the certainty of parental love and a cry of furious anger and resentment as retaliation for his frustrations. It was interesting that he had several dreams in which he had to flee from his mother because he feared she would punish him terribly for masturbating. These dreams were very much disguised and seemed to be memories of the episode that occurred at the age of two when his mother discharged his nurse because she masturbated him. He felt that his furious resentment was more dangerous

(and therefore it was more deeply repressed) than his desire for love because it would hurt and destroy the very people from whom he wished love and support. Of course he avoided for a long time any recognition of the real behavior of his parents lest his feelings get the better of him, and his world—uncertain as it was—be destroyed. This was the reason, also, for the repression of his feelings, which had proceeded to the point where he even had no feeling of discomfort about his speech difficulty. Only after a long period of treatment did he become aware of the embarrassment and difficulty his stutter caused him, whereupon he became furiously angry at the symptom. His basic conflict, to repeat, was his desire for the mother's love and his bitter resentment because he did not receive it; i.e., it was a pregenital conflict centering around oral and anal activities. His phallic and Oedipus conflicts, of which he had many, were in part more repressed and basic than his oral and anal ones and in part superimposed upon and involved in them.

I have gone into some detail concerning the complicated emotional basis for the symptom of stuttering because I have wanted at the same time to show the complexity of the distortions in the personality of this patient and his resultant incapacity for leading a successful life. There are, however, other dynamics involved in the problem of stuttering that are not illustrated by this patient but that should be discussed.

In the history of stutterers there is a fairly constant story that the stuttering started as the result of a fright. A sudden fright causes a severe startle reflex. It makes the child catch his breath. This catching of the breath means that the individual, child or adult, has regressed temporarily to the arrhythmic breathing of early infancy. In the adult and older child this regression lasts only for a very short time; in the small child it lasts longer, perhaps for several months. The arrhythmic breathing of early infancy furnishes a very in-co-ordinate flow of air which makes clear, easy speech impossible, and if it persists very long, stuttering becomes the only speech possible.

While the fear starts the startle reaction and the regression to the arrhythmic mode of breathing, it also arouses the child's instinctual desires—particularly those of the oral stage—thus: When the small child is suddenly frightened, he wants to be held in his mother's arms and to have all his tensions relieved as they were when he would satiate himself by sucking at her breast. These desires have been repressed into the unconscious but now because of the fright suddenly try to break through

into consciousness in order to be gratified. The child, because he has repressed them, becomes more frightened as he perceives unconsciously that they are being re-energized. He tries to repudiate them as he did originally because he knows they cannot be gratified and because he regards them as babyish. At the same time the resentment he had felt when he was weaned—which he could express only by a wish to bite the mother's breast spitefully—is also reactivated by the re-energizing of the desire to suck his mother's breast and be protected and comforted by her. Now these two desires, which occurred originally at two different times but which, because they were repressed into the unconscious, have now lost all connection with the reality of time, are themselves in conflict. Too, the incompatibility between the desire to be comforted and the desire to express resentment interferes with either desire becoming conscious or being expressed by action. Instead, both remain in the unconscious, but their reactivated energy starts to innervate the muscular actions of sucking, crying, and biting. When he attempts to speak, he innervates the already innervated muscles. The purpose of his innervation is to speak; the purpose of the instinctual innervation is to suck, to cry, and to bite—which movements are opposed to the movements of speaking.

The presence of the unconscious conflicts and the attempt of these instinctual components to break through into consciousness are indicated to the ego of the stutterer by a feeling of anxiety. This anxiety acts in the same way as the original fear: it further disturbs the rhythm of breathing. In addition to his other problems, the stutterer has only a limited volume of breath to use for speech, and this volume varies in an irregular manner from time to time, so that he has less breath to use. The result of these various factors is that he cannot form his words clearly and fluently and so stutters. The excess innervations eventually form facilitated reflex pathways. The neuromotor system becomes habituated to respond with certain movements, and the slightest increase in its innervations follows the original patterns rather than being directed to produce more effective speech. It is well known that the stutterer tends to speak more poorly when tense, anxious, or excited.

Stutterers usually have serious unconscious conflicts stemming from the Oedipus situation, and in an attempt to solve them regress to the anal-sadistic and oral levels of development. But during the anal-sadistic stage, too, they had serious conflicts which they tried to solve by regressing to the oral stage. Thus their ability to deal with the conflicts of the Oedipus period has been lessened by the conflicts and the resultant regression

during the anal-sadistic stage, and by the marked fixations at the oral and anal-sadistic stages because of the traumatic events of these periods.

Stuttering does run in families and may be the result of identification between the developing child and the stuttering parent. However, it is possible that the regression to the disturbance in the function of speech is due partly to constitutional causes. But even without constitutional cause the stutterer would still have regressed, expressing his conflicts not by stuttering but by other oral and anal symptoms.

Treatment. I have tried to make clear the fact that the symptom of stuttering is not a minor problem to be solved by advice, admonition, or punishment, as so many parents believe, or by speech retraining, as practiced constantly by psychologists and educators, but is the end result of complex intrapsychic conflicts that need intensive and expert treatment for their solution. And even in the hands of the expert, the neuromotor habit formation which I mentioned earlier produces another treatment problem: though the intrapsychic conflicts may be resolved completely by intensive psychotherapy, a certain amount of stuttering remains. It is advisable, therefore, toward the conclusion of psychotherapy to supplement treatment by speech retraining, i.e., by breathing exercises—to reinstate a more rhythmic type of breathing—and by conscious practice in speaking slowly and clearly and in forming the word sounds correctly.

PSYCHOGENIC TIC

CASE 30. A boy of six is referred because he has a facial tic, is restless, picks his nose, sniffles, has enuresis and temper tantrums and is tense generally. The tic consists of spasmodic movements of the eyes, twitchings of the corners of the mouth, many grimaces, and constant sniffing. Occasionally he seems to stare fixedly to one side. The nose picking is fairly constant. The enuresis occurs both during the day and at night. He has temper tantrums when he has to do something he does not want to do. Both the enuresis and the tic began at the age of three, their onset having been gradual.

History. The father was unemployed and the mother was somewhat antagonistic toward him. She seemed more interested in her two sisters, for she was willing to leave her family to stay with her sister in another city during the latter's confinement. She felt that the children in the neighborhood were not good enough for her son to play with. She said she wished her son had greater opportunities than he had

and that his enuresis stopped during his stay at an expensive camp the previous summer.

There were two children in the family, the sister a three-year-old. A maternal aunt who had been living with the family for three years suffered from a depressive psychosis that began about eighteen months previously following the birth of a daughter. Her husband and child also lived with the family.

His mother's pregnancy terminated at term. The birth was unaided and labor lasted fifteen hours. The patient was a small baby, his birth weight being 5 pounds, 4 ounces. Since the mother suffered from breast abscesses, he was bottle-fed, and during the first month there was difficulty in finding a formula that would agree with him. At six months, he had trouble with his teeth and it was necessary to have his gums lanced. He was weaned from the bottle at eleven months. His toilet training was started very early. According to the mother, he was clean and dry after three months and until the enuresis began at the age of three years. At six weeks he was circumcised. He walked at fourteen months. He did not speak clearly until the age of three. At four he had a tonsillectomy, which had no effect on his symptoms. His mother said he handled his genitals frequently, for a second or so each time, but that there was no rubbing.

Examinations. The physician reported that the boy was thin, somewhat sickly in appearance, and apparently undernourished. The mother said he was finicky about his food. Except for the motor symptoms, no signs of physical disease were found. An electroencephalogram showed there were abnormal electrical waves, ranging in amplitude from 25 to 100 microvolts and in frequency from 3 to 6 per second, in all areas of the cortex. The amplitude of 100 microvolts was particularly marked in the right and left parietal areas.

At first the patient was friendly with the psychiatrist. He welcomed the attention given him but changed the subject when asked about his problems. The only thing he would say about school was that it was nice. He talked little about his father. He spent much of the time relating murderous fantasies: he brought poison to kill the boys at school; he was going to kill the psychiatrist, too. He appeared to be very indifferent about his enuresis but said that his mother wet the bed and that he had to change it for her. He showed no hesitation in describing his temper tantrums. He had a temper tantrum when he was not allowed to stay with his mother. He said he had to see her and although he

promised to come back to the interview if he saw her, he broke his promise.

Diagnosis. Four conditions must be considered in making a diagnosis of the case.

1. Chronic Encephalitis: Chronic encephalitis often causes motor signs of a bizarre type, particularly common among which are spasmodic associated movements of the eyes. These motor disturbances are often accompanied by changes in personality and behavior. Epidemic encephalitis is an illness in which recovery from the acute stage is usually accompanied by the gradual development of chronic symptoms. The acute stage, particularly during an epidemic, may be very mild—often so mild as to be diagnosed as an attack of influenza—while the chronic symptoms may be very severe. Here in favor of the diagnosis of encephalitis is the rather gradual onset at the significant age of three years, many motor disturbances, including what might appear to be spasmodic movements of the eyes, and the abnormal waves found in the electroencephalogram. Against chronic encephalitis is the fact that the abnormal motor signs are not those found typically in chronic inflammations of the brain. The movements of the eyes are not spasmodic. They are under voluntary control, and the patient can readily inhibit the movement or stop it when it starts, which the postencephalitic patient cannot do. A careful neurological examination showed no signs of chronic inflammation of the brain, while the vast majority of cases of postencephalitis show unmistakable signs of organic neurological lesions. The abnormalities observed in the encephalogram are found in other conditions where no evidence of chronic cerebral inflammation is found. In fact, the great majority of children seen in the clinic at Temple University Hospital, where the clinical diagnosis is conversion hysteria, anxiety hysteria, compulsion neurosis, or character neurosis, show similar electroencephalograms. Since these electroencephalograms are all done by one competent person, Dr. Joseph Hughes, I believe that as yet we do not know what a normal electroencephalogram in a child is. There is no history that the boy had an illness resembling encephalitis at the age of three. This point is not conclusive, however, owing to the uncertainty of a history obtained from relatives. Temper tantrums have no diagnostic significance. The data does not favor a diagnosis of chronic encephalitis.

2. Acute Infectious Chorea: Careful neurological examinations reveal none of the signs—characteristic choreiform movements, hypotonia, increased pronation of the hands, unilateral weakness, disturbances of

associated movements, adiadokokinesia and asynergia—typical of chorea. Chorea is a self-limiting disease and does not persist unchanged for over three years.

3. Schizophrenia: His social behavior has some characteristics that might be described as schizophrenic. He was obviously afraid of the psychiatrist and had a very poor relationship with him, yet he acted as though he were unafraid by daring to leave the office without permission. He told many wild stories, perhaps to make an impression on the psychiatrist, knowing all the time they were untrue; or he may really have believed the stories, in which case they would be actual delusions.

4. Psychogenic Tic: The combination of symptoms—temper tantrums, enuresis, restlessness, nose picking, and general tenseness with twitchings of the voluntary musculature—presents a syndrome that is characteristic of psychogenic tic. Fenichel¹ points out that psychogenic tic owes its origin to a process of conversion. As in hysteria, the voluntary musculature refuses to serve the ego and functions independently of the will. He says that tics are phenomena that form a series of links between hysteria and catatonia. The resemblance of this boy's behavior to both conversion hysteria and schizophrenia has already been noted. Fenichel also points out that the mental life of a ticquer shows a well-defined anal character, which in the patient's case is illustrated by his sadistic fantasies, his feelings of omnipotence, his belief in magic, and his use of wetting as a method of revenge.

I believe the diagnosis is one of psychogenic tic.

Psychopathology. It is difficult at this point to be definite about the psychopathology because the data is so meager. It is evident that the boy is very much attached to his mother—he had a temper tantrum when separated from her—but this attachment and its methods of expression indicate that he is getting little satisfaction from it. His history states that his symptoms began at about the time of the birth of his sister. Previous to that event were certain deprivations—i.e., no breast feeding, difficulty in finding a food that agreed with him—and certain restrictions—he was toilet-trained at the age of three months, which would make him feel that his relationship with his mother was not a satisfactory one and that she probably disliked him. Such a feeling would, in turn, make him very insecure in his relation with her and therefore not strong enough to tolerate the trauma of his sister's birth and the further reduction in maternal attention that this entailed. Further-

¹ Otto Fenichel: "An Outline of Clinical Psychoanalysis," *Psychoanalytic Quarterly*, 2:94, 1933.

more, in talking with the mother I found that she really preferred the sister, whom she characterized as perfect.

Having taken upon herself the care of the psychotic aunt and baby cousin, the mother's attention has had to be more withdrawn from the boy since the symptoms started, and because of the deprivation his longing for her attention has increased but at the same time has become associated with marked feelings of antagonism and hostility toward her. The antagonistic feelings are expressed in his openly aggressive behavior, in his day wetting—which is a conscious retaliation—and perhaps similarly in his bedwetting. The desire for her attention is expressed in his clinging to her and forms part of the motivation in his tics and bedwetting, which attract her attention. With regard to his statement that his mother wets the bed and he has to change it for her, he is expressing a wish that she give him more care; i.e., that she pay more attention to his genitals and to him. It also expresses his interest in her urination and her genitals.

His attachment to the mother results in greatly increased hostility toward his rivals—sister, father, aunt, and cousin—they are the “boys” whom he would like to buy poison for and to kill. He fears these hostile feelings so much that he cannot tolerate them when directed toward their real objects—the aunt, her child, etc.

Since the patient's relationship to his mother is the core of the problem, it is important to understand her relation to him. She toilet-trained him very early, and although she denied that the boy masturbated, her description of the touching of his genitals indicated that she had observed the act carefully and desired to check it. She was snobbish in regard to his playmates. Although she said she would like him to have more opportunities, her behavior in devoting herself to her sisters at the expense of her own children indicated a feeling of antagonism to the boy, an antagonism not so much the result of his behavior but an expression of her basic antagonism to men, of which she was unconscious. The father appeared to be a weak person submitting docilely to his wife's behavior.

In short the boy, having been rejected by the mother and feeling insecure as a result, attempts to cling to her. He is unable to express directly his hostility toward her because it is in conflict with his love for her. Conversely, he is unable to express directly his love for her because it conflicts with his hostility toward her. Also, the attachment to her is burdened with many feelings of guilt and fear because it keeps him constantly hostile toward his sister and his father. The father's

weakness makes it difficult for the boy to express his hostility toward him.

In order to solve these conflicts, of which he was unconscious, he regressed from the phallic to the anal-sadistic stage of development, his anal-sadistic drives and mechanisms appearing partly directly and partly as symptoms.

The discussion of the psychopathology of the case does not disclose the specific reasons for the tics, and since no neurotic symptom appears without a specific reason for the particular form in which it occurs, the psychopathology cannot be fully discussed until this reason has been discovered. However, this case has not yet been investigated intensively enough to ascertain the specific psychopathology.

THE PSYCHOPATHOLOGY OF TICS

The problem is better illustrated by the following case, from which I am presenting only the data pertinent to the tic.

CASE 31. A boy of ten suffers from sleeplessness and blinking of the eyes. His birth was rather difficult. He was breast-fed for two months and allowed to have a bottle for the next three years. He showed no particular reaction to the weaning from the breast. He was clean from three months of age. His bedwetting stopped when he was three years old—the time when he was weaned from the bottle and the time of his sister's birth. The mother was quite sick during the pregnancy with the sister. The blinking of the eyes started during the mother's pregnancy with his brother, who is now a year old, and became much worse after the brother's birth.

The boy said that the blinking of the eyes started immediately after the mother, in anger over a minor offense, had thrown a book at him and hit him in the eye. During this time he had been doing a great deal of peeping, particularly at his nude sister and in his parents' bedroom. He expressed considerable fear lest his mother punish him by injuring his left hand, or by deserting him by sending him away if he were dirty. He had a real basis for this fear. The parents got along very poorly and the mother constantly threatened to leave. He was also positive that his idea of a talion law—i.e., that hostile wishes would rebound on the head of the ill-wisher—was true.

The boy's blinking of the eyes had the dynamics of a conversion symptom, serving as a compromise between two tendencies—his unconscious desire to look at sexual activity and his partly conscious fear that his mother would blind him for such looking. Looking itself was

a regressive substitute for masturbation, for which the child was severely punished by the mother,² shortly before the eye blinking started. In general, the tic movement portrays one or another aspect of a conversion symptom. It may represent preponderantly the partial, distorted, or displaced expression of an unconscious, instinctual, autoerotic desire. The twitchings of the corners of the mouth of the boy in Case 30 might represent a distortion of the act of smiling—in ridicule—a hostile impulse against the mother. The grimaces might represent a distorted attempt to make a face at her. The sniffing might represent a distorted attempt to gratify his desire to smell her. (Children are often erotically excited and pleased by the smell of the parent to whom they are attracted sexually, and often during the parent's absence will smell her clothes to satisfy their longing for her.) He is unconscious of the presence of these impulses and would feel embarrassed and frightened if they appeared in consciousness. The repressed impulses, therefore, appear in a partial, distorted, or displaced form in the tic movement.

The movement may represent an attempt to avoid punishment for an instinctual desire. The attempt may be partial or distorted or may express itself as a complicated motor ritual. The tic of the boy in Case 31 was an attempt to avoid punishment by blindness.

Usually it is a pregenital instinctual impulse that lies at the basis of the tic. In Case 31, it was the desire to peep, to which the patient had regressed because of his fear of phallic masturbation.

DYSFUNCTIONS IN MOTILITY IN CHILDREN

I believe it is important to discuss here the whole question of dysfunction in motility in children. Symptoms such as restlessness, fidgetiness, and tics—i.e., disturbances of muscular function—are fairly common. They are often confused with chorea. Although common and a source of great annoyance and worry to parents and educators, not much clinical attention has been paid to them.

It is well known that chronic restlessness occurs after head injury. Schilder,² among many others, cites a number of such cases and says that sadism, restlessness, and excitement are common symptoms of psychosis after head injuries.

Levin³ believes that most restlessness is the result of some structural

² Paul Schilder: "Psychic Disturbances after Head Injuries," *American Journal of Psychiatry*, 91:155, 1934.

³ Paul M. Levin: "Restlessness in Children," *Archives of Neurology and Psychiatry*, 39:764, 1938.

defect of the frontal lobes, usually of developmental origin. He found that restless children had an average I.Q. of 80, whereas nonrestless ones had an average of 92. He believes there is a symptom complex of restlessness, morbid hunger, and mental defect. When there was a normal I.Q. and no cerebral disease, he found the restlessness less marked and believed it was due to faulty training (overindulgence or neglect on the part of the parents), an environmental conflict, or a failure of achievement in school. He likened this type of restlessness to that shown by neurotic dogs in Pavlov's experiments.

Both of these authors—as well as many others—express the concept that restlessness and such disturbances of motor function as tics often have some organic pathology as their basis. In cases where no organic pathology is found Levin concludes that the causative factors are the same as in psychological problems not involving motor disturbances. He does not answer the question why in certain children disturbances of the motility are the prominent symptom of neurosis.

In order to understand motility disorders, it is necessary to realize the importance of the instinctual pleasure to be derived from bodily movement itself. Both the direct observations of the pleasure a young baby obtains from simply moving his extremities and the introspective observations of adults into the pleasure they feel in doing the same thing are evidence of the fact. In children, abundant activity often serves to liberate a great amount of instinctual drive which eventually cannot confine its gratification to bodily movement only but may flow over into feelings and reactions of sexual excitement or into conscious aggressive and hostile feelings. Instinctual drives, either sexual or aggressive, may use the muscles as the vehicle for their expression. The function of bodily movement becomes libidinized; i.e., a source of instinctual gratification. This process reaches its height during the period when the child is learning to walk; i.e., during the anal-sadistic period. Waelder⁴ believes that muscular action is so important to the child at this time that the anal-sadistic period more correctly should be called the anal-sadistic-muscular stage of development. Learning to walk also has another pleasurable function. It enables the child to overcome his anxiety lest his mother leave him. Formerly, he had to suffer passively all the anxiety aroused by the fact that she could walk away from him and he could not prevent it. Now not only can he walk after her but he can also actively walk away from her. Gratification of instinctual

⁴ Robert Waelder, in personal communication with the author.

pleasure through motion is therefore a partial component instinct drive that is apparently at its height during the pregenital period, probably during the anal-sadistic stage.⁵

From my own studies I have been able to delineate three types of cases of chronic restlessness in children:

1. Hyperactivity, sometimes associated with other signs of pathology and sometimes not.
2. Fidgetiness, usually associated with symptoms of chronic anxiety.
3. Restlessness of specific parts of the body, i.e., tics. The parts most commonly affected are the eyes, face, head, and neck.

1. Hyperactivity: Some persons are consistently more active motorially than others. They show no signs of a definite neurosis, and when their history is studied it is found that their hyperactivity goes back to birth and was present even during the latter part of their intra-uterine life. Therefore, as far as our knowledge goes at present, it would seem that their hyperactivity is a constitutional trait. The expression of such a constitutional trait can be altered only by definite methods of training, which has to be severe if the child's hyperactivity is to be influenced permanently. Such training is bitterly resented by the child and sometimes results in the development of a character whose outstanding traits are hostility and resentment—the chronic aggressive character pattern. In these cases constitutional hyperactivity is one of the causes of the chronic aggressive character pattern. In other cases it is a symptom of the same character pattern. If the child's antisocial behavior is the result of his struggle against his unconscious passive desires, he may overcompensate by being consistently antagonistic and hyperactive. I will discuss the psychodynamics of this character reaction pattern in a later chapter. Such a child's hyperactivity is not constitutional but is a symptom of his character neurosis.

2. Fidgetiness: Fidgety children show the signs of chronic anxiety. I have already stated that this condition is often confused with chorea. The restlessness is an attempt to cope with and reduce the feeling of anxiety which has been produced by a feeling of insecurity in the child's object relationships. His ability to form secure object relationships with his parents has been frustrated for one of several reasons: He has been

⁵ There is need for many more extensive and intensive studies into this form of erotic gratification in childhood. Until such have been made, all attempts at an accurate explanation of phenomena such as catatonia and tics will be only partially successful.

deprived of a parent. His parents' attitudes toward him have been basically rejective, however much the rejection has been denied by overprotection. He has been overindulged and so is not prepared to deal with a situation that forces him out of the center of attention. When a child who has lived in such a situation is faced with the relative lack of attention incidental to the birth of a new child in the family, he feels very insecure and anxious as to his true status. These situations are similar to those that produce restlessness in animals. Cook ⁶ pointed out that an animal develops a neurosis when (1) it is asked to discriminate between two closely similar stimuli; (2) it is asked to delay its response to a stimulus too long; (3) it has become accustomed to be used as a test animal and then the practice is stopped and its cellmate is used instead. The symptoms of the neurosis are violence, destructiveness, struggling, squealing, biting and barking without cause, ticlike movements, tremors and sudden starts, nocturnal activity, and loss of the ability to discriminate.

A parent whose overprotection is based on rejection frequently trains the child in such a way that he has to make too fine a distinction between what is permitted and what is not. A similar type of parent is often overanxious to make the child conform too quickly. He requires him to replace too abruptly the use of the pleasure principle as a guide to life by the reality principle. The third situation described by Cook is that found when a new child is born into the family. Each of these situations produces a state of anxious apprehension which is very painful to the child, and in order to overcome his discomfort, he wants to attack and annoy the persons in his environment, particularly those who are making life so unpleasant for him. In other words, he brings into play his aggressive impulses, whose usual vehicle of expression is the motor system. If the child's character is based on a chronically aggressive pattern, his restlessness is often a purposeful one and he may be quite aware of its purpose. The child who has been subjected to any one of the three situations mentioned by Cook has learned to be afraid to express his aggressive impulses directly. He is usually unaware that he wishes to attack his parents and siblings, but the energy of the repressed desire innervates his general musculature, producing movements that seem purposeless and that seem to him to be beyond the control of his will. If he tries to control these movements, his restlessness becomes involuntary fidgetiness.

⁶ Stewart W. Cook: "A Survey of Methods Used to Produce Experimental Neurosis," *American Journal of Psychiatry*, 95:1259, 1939.

Darwin⁷ long ago pointed out that a hungry animal goes through a great many unuseful motor acts when he sees his meal and that the actions cease as soon as he starts to eat. An enraged animal does the same thing when anticipating a fight. The muscular action is used largely as a preparation for an anticipated act, either erotic or aggressive. If the animal is frustrated in his desire to gratify his instinctual impulses, he will continue to repeat the anticipatory behavior. If he is interrupted in his gratification or fears to continue it, he will return to the anticipatory behavior. In short, he will give up his attempts to gratify himself and will regress to anticipatory behavior. The very young baby has not the capacity to control his actions and when frustrated tends to innervate all his musculature. As a result, his actions are in-co-ordinate and purposeless.

Children who have been subjected to any of these three situations, particularly to the methods of training seen in the first two, are unable to know whether they can have what they want or when the parents will be displeased with them if they attempt to get it. They are forced to regress psychically from using their motor energy to obtain what they desire to the stage of anticipating. They have also regressed developmentally from the ability to use their muscles purposefully to the stage when they were unable to do so. Therefore they show a psychological and developmental regression to the expression of aggressive impulses through the in-co-ordinate and purposeless use of the motor system. Secondarily, they attempt to control this generalized motor activity, and fidgetiness results.

The regression occurs because they are unable to identify with their parents in adequate purposeful motor acts. Their attempts at identification have been frustrated, either by the rigidity of their training or by their overwhelming jealousy situation. They have been unable to gratify adequately the sexual and aggressive impulses. In the sexual field, they cannot gratify their desires because they fear punishment directly by their parents or, if in the latency period, by their superego, so they repress them for the same reason that they inhibit and repress their aggressive impulses. In the individual case, it becomes important to know whether the sexual or the aggressive impulses are more strongly repressed, although in most cases the repression bears on both. In both situations the repression produces anxiety. The child tries to deal with the anxiety as he would with fear: by attacking the object that deprives him of gratification. But the attempt is met by social disapproval and

⁷ Charles Darwin: *The Expression of Emotions in Men and Animals*, D. Appleton and Co., New York, 1890.

punishment. The child attempts to adjust to his fear of social disapproval by repressing this secondary aggression. In order to keep both the instinctual desires and the secondary aggression repressed, the child has to regress to the stage of motor anticipation. This increased muscular tension appears as purposeless movements and fidgetiness.

This is one group of causes of fidgetiness. Levy⁸ and Mahler⁹ have pointed out another group. They believe that the symptoms of fidgetiness and tics occur in motor-minded individuals, as indicated by the fact that as children they were unusually active in utero and in infancy. Levy states that both hens and horses show ticlike movements when their natural activity is restrained artificially and that these cease when the restraint is removed. Once the restraint of movement has established a tic, it—like the habit of finger sucking originating from a simple deficiency need—may be activated as a secondary phenomenon in states of fatigue, anxiety, anticipation, restlessness, discomfort, or monotony. Head rolling and similar rhythmical head movements in infants are analogous to the head shaking of chickens, the weaving tics of horses, etc. Such movements in infants, when frequent enough to be regarded as tics, are found to be related in some instances to restraint of movement in the crib, and in other instances to absence of play material (monotony). In some instances, he thought they had their origin in passive uterine movements, for they could be allayed by rhythmical rocking activities. He studied various types of movement restraint in children—play pen, the leash, being locked up in a room, prevention of creeping, and necessary immobilization in a plaster cast—and found that when the restraint was removed the children became hyperactive. Several cases showed periods of “wild” running around in circles—a sudden release of pent-up movement. He thought the difference between the hyperactivity of the children and the stereotyped movements of the animals could be explained in terms of the difference in the method of restraint. In the latter, it was used consistently; in the former, it was interspersed with intervals of freedom.

Mahler points out that the parents of children who are fidgety or have tics place many restrictions on the child's use of his muscles. They are ambitious and require perfection in their children but are not in-

⁸ David M. Levy: “On the Problem of Movement Restraint,” *American Journal of Orthopsychiatry*, 14:644, 1944.

⁹ Margaret S. Mahler, Jean A. Luke, and Wilburta Daltroff: “Clinical and Follow-up Study of Tic Syndrome in Children,” *American Journal of Orthopsychiatry*, 15:631, 1945. Margaret S. Mahler: “Tics and Impulsion in Children: A Study of Motility,” *Psychoanalytic Quarterly*, 13:430, 1944.

terested in locomotor maturation, social and athletic ability, or independence. In the majority of cases, the development has been interfered with by the parents in one of two ways: (1) there has been restriction of motor outlets, particularly before the child has mastered his partial skills or thoroughly integrated his total motility; (2) there has been indirect restriction of motor outlets by the parents' possessive over-protectiveness and overstimulation of the child's infantilism. (The parents rationalize and excuse their practice of close bodily contact with the child by thinking the child has fears. Phobic fears are common in these children, disturbances of sleep preceding and accompanying the tics.) The second cause is more pathogenic than the first. There is a marked contrast between the parents' lack of interest in and restrictive attitude toward motor activity and the child's motor-mindedness. I have seen many cases where the fidgetiness was the result of the adverse attitudes of the parents to the child's spontaneous motor activity. There are parents whose children are inclined to be hyperactive and who seem to understand intuitively that restriction of movement is painful to the child. They restrict his muscular activity by tying him or by insisting on long periods of sitting still as a punishment. Such a procedure only increases the child's restlessness, for anger and aggressive impulses engendered by the adult's interference are added to the need to use the muscles for ordinary activity. And since the child cannot express his resistant feelings verbally, he tends to regress to the motor expression of anger. But this, too, is forbidden. He must sit still and be "good." In his unhappiness and resentment, he would like to masturbate but is forbidden. He cannot touch his genitals, so feels a need to touch other parts of his body or to move in ways that will give genital gratification. The increased muscular tension engendered in this way lasts for a long time after the punishment is stopped.

Mahler states that in other cases the child's use of his muscles has been restricted by an illness that occurred before he had thoroughly integrated his total motility. In a number of my cases, the fidgetiness followed a long period of illness. There are several reasons for this. Kardiner¹⁰ has pointed out that if there is an ego defect or a defect in the psychic image of the ego, the individual is not capable of expressing his aggressive impulses efficiently. The aggression tends to be stored up until it explodes in mass action. If a child lies in bed with a long-continued illness, he is not able, because of weakness, medical prohibitions,

¹⁰ Abram Kardiner: "The Bioanalysis of the Epileptic Reaction," *Psychoanalytic Quarterly*, 1:375, 1932.

etc., to use his muscular system to express his aggressive impulses. The latter are stored up to be liberated later, usually not in a mass action but in slow degrees, so that over a long period of time the muscles are in a state of tension and the fidgetiness serves as a partial release.

Schilder ¹¹ has pointed out that organic diseases occurring early in the child's life make him more dependent on the parents, and they, in turn, tend to overprotect the child. The satisfaction in such a situation places a premium on the child's masochistic dependent attitude. In order to continue the gratification of his dependent masochistic desires, he would like to remain ill. On the other hand, he longs to be free, active, and independent again. The conflict between his desire to stay in bed and be petted and his desire to be up and about is worked out through his motor system. The first-mentioned phase of the conflict inhibits the use of his muscles; the second increases their use. This conflicting innervation of his muscles results in more and more purposeless movements until they become fidgetiness.

These results occur directly. Indirect results occur also. After a severe illness children are often unnecessarily restricted from too active behavior by their parents, who fear a repetition of the anxiety and mental discomfort caused by a loved child's serious illness. Since muscular activity is a part of life, such restrictions tend to make the child restless. He appears to have a purposeless excitement of the motor system. This is clearly seen in the expression "tickles in his feet," used for the small child whose active life has been interfered with by a rainy day.

3. Tics: Restlessness of specific parts of the body only—as described in Cases 30 and 31—is known as a tic. Mahler states that intermittent and permanent tics may be classified tentatively into three types:

(1) Those that develop during the prelatent period. The hyperactive child obtains a great deal of sensual pleasure from an infinite variety of purposeful bodily movements. He has to learn to relinquish this pleasure because the movements are inappropriate and lack realistic purpose, or because his parents and other adults dislike them. He may not wish to do so but can and does do it voluntarily for a period of time when outside pressure or his inner demands to be pleasing to his parents call for temporary control. Later, usually at the age of six or seven, the general powerful repression that takes place at this time causes him to lose his ability to stop the movements voluntarily. The high reversibility potential is lost. The movement persists though it

¹¹ Paul Schilder: "The Concept of Hysteria," *American Journal of Psychiatry*, 95:1388, 1939.

brings the child no conscious feeling of sensual pleasure and though it is no longer under his control.

(2) Tics that develop during the period of latency. In these cases, there is always a preschool history of fidgetiness and playful immaturity. If such a child experiences an increase of instinctual tension such as may be produced by an automobile accident or other trauma, or if he undergoes a sudden heightening of a sense of guilt through religious instruction on the "sin" of masturbation, with threats of its consequences, he develops volitional, so-called "nervous habits," like blinking, picking the nose, or rolling on the stomach. These acts are autoerotic and are accompanied by an anxiety state. The parents oppose these actions by threats of corporal punishment or other consequences. The child tries to stop his actions, and the real tic appears a few weeks later, frequently coinciding with or followed by a general bodily jerkiness. The first manifestation of the tic is never of a permanent pattern. Before long, other tics appear as defenses or secondary elaborations of the first. The generalized jerkiness, darting about, and tossing are usually confused with the symptoms of chorea minor. The differential diagnosis between tic and chorea is indeed often very difficult, and it sometimes happens that children known to have had multiple tics acquire rheumatic fever and chorea many years later.

(3) Tics appearing in adolescents and in adults. The tic movement symbolizes an eroticized activity of some organ. The psychodynamics of this type of tic are like those of a traumatic neurosis. They are the tics that Ferenczi described as single and living a so-called parasitic life. They are isolated from the ego function and are therefore very difficult to reach therapeutically.

Levy studied the restraint of movements involving parts of the body—"binding restraints"—in contrast with external barriers to locomotion. He explains the absence of resistive behavior or emotional outbursts among infants subjected to swaddling clothes or cradle boards by pointing out that such restraint is a modification of activity which has not been exercised sufficiently to represent a real need. He investigated the methods of mechanical restraints applied to prevent finger sucking and found that their use did not result in hyperactivity unless the restraints were used over long periods of time. A record of the immediate response of nineteen children to twenty-three experiences of mechanical restraint revealed a variety of behavior from apparent acceptance to temper tantrums. The most violent reactions were elicited by the elbow splint.

Levy applies the term "mechanical tic" to those ticlike movements that result from the use of restraint. He applies the name "psychic tic" to superfluous, involuntary, brisk, repeated, rhythmical movements set off by a mental process. In its manifestations it may be identical with tics resulting from mechanical restraint. Once a mechanical tic has started, it is subject to emotional influence. However, in psychic tic the origin is itself emotional. The restraint factor in many psychic tics represents an inhibition of an impulse regarded by the individual as dangerous or shameful. The repetitious feature of the deflected act may be due to its lack of fulfillment, a kind of unsuccessful attempt to satisfy an impulse with a part performance. Some tics are a simple acting out of a fantasy in pantomime. The act is not distorted or fractioned.

A study of the psychic content of tics reveals every variety of sexual and aggressive impulse in which fear of the consequences of the act inhibits its fulfillment. The result is seen in various partial representations of the act as originally intended (fractions, deflections, substitutions); or in protective gestures, to avert the danger, though the impulse is not overtly fulfilled even in aborted forms. The tics are simpler devices than compulsive movements. The former are partial manifestations of an intended act; the latter are often complicated, ritualized devices to protect oneself against an act that is not taking place. In the former, regardless of its danger, the impulse is paramount and the act breaks out, however distorted; in the latter, the danger is paramount, and whenever the impulse is felt, only the attempts to ward off the act immediately appear. Tics that appear to be a continuation of movements originally appropriate to the stimulus, long after the stimulus has disappeared, may be in a different category.

I have quoted at length from the reports by Levy and Mahler because they provide the best systematic observations on motility disorders in children and should be read by those interested in the subject.

TREATMENT OF DYSFUNCTIONS IN MOTILITY

Treatment for disorders of motility in children depends on whether the conflict is conscious or unconscious. In the former case, the parents require education as to the child's need for more opportunity for motor action. In the latter case, the child needs treatment to make his unconscious conflicts and fantasies conscious. Usually this must be combined with educative therapy for the parents. However, even though the environment is made more permissive for the child and his psychotherapy is carried through systematically, the motor disturbance, particularly

if it is located in a single muscular function like a tic, may still remain because the muscular functions have become highly libidinized. In order finally to overcome the movement, it may be necessary to induce the child to stop it consciously. This should not be attempted, however, until all the intrapsychic conflicts have been resolved.

Hyperactivity may be a constitutional trait or may result from cerebral injuries that remove part of the cortical control over muscular action. In either case such children need abundant opportunity for extensive free play.

When parents impose restrictions on the activity of a hyperactive child, the child feels frustrated and may react to his frustration by developing a chronic aggressive character pattern. He becomes hostile to all restraints and his hyperactivity remains unchanged. If he tries to curb his activity in order to please his parents, he changes from a hyperactive child to a fidgety one. He may be aware of the reason for his fidgetiness, or he may be unconscious of it, having repressed the whole conflict. In the latter case, even some of the fidgetiness may eventually disappear. The child, however, has an unconscious libidinal fixation to the muscular system. If a traumatic event occurs later in life and causes a regression, this regression will be to the complex of ideas and feelings centered on muscular action. In this complex there are many unconscious fantasies that will then have an opportunity to express themselves as uncontrollable muscular movements, and the symptoms will have all the characteristics of conversion symptoms—but at a pregenital rather than phallic level.

CHAPTER EIGHT

THE INTERRELATIONSHIPS OF ORGANIC AND PSYCHIC ILLNESSES

IN CONVERSION hysteria, ideas and feelings are repressed into the unconscious, where they form fantasies. These unconscious fantasies express themselves through disturbances of physiological function. The clinical syndrome of conversion hysteria—i.e., the fact that disturbances in the psychic life can produce disturbances of physiological function—has been known for many centuries, although its psychopathology has been known only for the last fifty years. However, conversion hysteria does not account for all the disturbances of physiological function in which no basic organic pathology is found. Nor does it account for the emotional reactions that are often present in individuals suffering from organic disease. In this chapter I will discuss some aspects of the effect of organic disease on the emotional life and also our knowledge of the effects of psychic conflicts on the physical organism in cases that are not conversion hysteria.

A CHILD TRIES TO DENY HE IS ILL

CASE 32. A fifteen-year-old boy is referred because of his antagonistic behavior toward parents and physician, because of frequent temper tantrums, and because he refuses to attend school. Before the age of fourteen he was friendly with his parents and did well at school—in fact, better than most boys of his age. He is athletic and is particularly interested in playing football.

History. He was the older child in the family, having a brother three years younger. His conception was planned, his mother was well during her pregnancy, and he was born at term. His birth was neither too long nor too short, and no instruments were used. He was breast-fed for six months and showed difficulty during weaning. His toilet training was not begun too early, nor was it too severe, according to the parents. He had no illnesses of note during preadolescence, and there were apparently no serious difficulties of adjustment.

His father, a successful businessman, was devoted to the boy and desired earnestly to see him do well and be successful. In the past year he had noted that when he was angry with the patient, the latter seemed bewildered. A paternal aunt suffered from schizophrenia. The mother was not as intelligent as the father, being characterized as "slow-minded." She was also more inclined to be impatient with the boy than was the father.

History of the Illness. The patient developed a severe attack of scarlet fever at the age of thirteen years, about the middle of the school term. He apparently recovered and returned to school for the remainder of the term, where he continued to do as well as he had before. During the early part of the following summer vacation the patient worked, although his father did not wish him to do so. In August of that year he began to complain of physical symptoms, and on being examined it was found that he had chronic endocarditis and myocarditis. He was put to bed and had to remain there for six months. After he was allowed to be up, he was placed by his physician on the following schedule:

To bed at 8 P.M.; lights out at 9 P.M. sharp.

Breakfast in bed between 7 and 8 A.M.

Arise at 10 A.M.

To bed for physical rest at 2 P.M.

Arise at 4 P.M.

The hours spent out of bed were to be devoted to unexciting reading, radio, and relaxation in or out of doors, depending on weather conditions. In the event of relaxation out of doors, direct strong sunshine was to be avoided, but reclining in an easy chair or hammock in the shade close to the sunshine was ordered. The application of an ice bag over the heart area for $1\frac{1}{2}$ hours in the morning and $1\frac{1}{2}$ hours in the afternoon was advised to lower the heart rate. Visitors were generally unwelcome unless they made the patient glad for their presence. They were not to remain with the patient for more than thirty minutes, nor were callers to disturb him during the rest periods

in bed. For the next four weeks, no exercise was permitted except the light exertion incident to going up and down stairs between the bedroom and the ground floor, and walking out to the lawn. The diet was to be as ample as was possible without digestive discomfort. It was to consist of fruit, vegetables, cereals, and dairy products in maximal quantities, with a minimum of animal proteins. Extra nourishment between meals, appetite permitting, was suggested as mild forced feeding for the purpose of increasing his weight. Tea, coffee, the "cola" drinks, as well as spices and condiments in excess (salt, mustard, pepper, vinegar, etc.) were forbidden.

On this regime, during the first month, his progress was splendid, because he conformed to the physician's directions. He had to conform, for his pulse rate was so high (154 per minute) and his heart action so tumultuous that he found it difficult or impossible to do otherwise. During this brief time there was a gain of ten pounds in weight and the heart rate dropped to 80 or below. When the patient found himself so much better, he became thoroughly "disgusted" with himself and with medical attention, regarded his improvement as recovery, and began to break all the rules. He refused to co-operate, which angered and annoyed his parents. He in turn reacted with great counterantagonism and more complete defiance of his regime. Also he refused to return to school when the time came to do so.

Examinations. In the first psychiatric interview I observed that he was a gangly boy who looked much older than his years. He was both suspicious and frank. He said there was no difficulty in school but he did not wish to return because he would be retarded a grade. His father was complaining about his absence from school and about his wanting to engage in all the activities of the neighborhood boys. He was still under medical restrictions, which he had broken. He was bad-tempered and in difficulty with his parents. In a subsequent interview I noticed choreiform movements of the hands. He became angry when I mentioned them, said he thought the interviews were useless, and after a few minutes got up and left.

His behavior during interviews was the same as that of which his parents and physician complained. If any needful attention was directed to the fact that he was ill, he became very angry and either repudiated the idea that he had an illness or repudiated the person who drew his attention to it.

THE PSYCHOPATHOLOGY OF UNREASONABLE REACTIONS TO PHYSICAL ILLNESS

THE DENIAL THAT ORGANIC ILLNESS EXISTS

What was his reason for repudiating the fact that he was ill—a repudiation that caused him to behave in a way that might have serious consequences for his life? In general, human beings show one of three types of reaction to physical illnesses. They may repudiate the fact that they are ill and try to convince themselves and others that they are not. Others accept being ill cheerfully—in fact, too cheerfully. They follow the physician's directions meticulously until such time as he suggests that they begin to convalesce and return to a more active life. They repudiate the idea and offer a thousand reasons why they should continue to live as they were compelled to during the height of the illness. If the physician continues to insist on their recovery, they repudiate him as a person with little professional skill. In the first type, the patient refuses to admit he is ill; in the second, he refuses to admit he is getting well. The third type of reaction is the one we should like all our patients to show. They accept the fact that they are ill and conform to the necessary methods of treatment but at the same time do not wish to overdo these methods and remain ill forever.

To get back to the boy. He says that he feels well and therefore does not see the necessity of living such a restricted life, which is not only boring but keeps him from joining in the pleasurable activities of his friends. He complains that his restrictions prevent his getting the pleasure from life that his associates do. His pride seems to be hurt by the fact that he is forced to live in a babyish, dependent manner and that he is not permitted to exercise independent initiative.

His conscious reasons for his behavior are very childish. He clings to them as being quite valid, although he knows that with temporary care the probabilities are that he will improve and that even if some disability remains for the rest of his life, it will not greatly interfere with his success and happiness. Although his judgment and intelligence are good, his behavior and his reasons for it are inconsistent with his knowledge of the facts. It is this amazing inconsistency in his thinking and behavior that is so infuriating to his parents and physician and that betrays the fact that he must be unconscious of the real motives and reasons for his behavior.

Although in this case the unconscious reasons are not yet known,

from the intensive studies of other cases it has been found that there are intrapsychically valid reasons for behavior such as his. The unconscious mind of the adult, the adolescent, and the child of the latency period is the mind of the child of the prelatent period. During this period every child suffers from two fears—that he will do something for which he will be punished by losing (1) his parents' love or (2) his ability to express his love to others because of the mutilation or destruction of his genitals. The form of the fear differs according to the sex. In the boy it is that he may do something for which he will be punished by the mutilation and loss of his genitals. In the girl it is that she will not be loved and desired or have her need to love and be loved satisfied because her genitals are not satisfactory and lovable. These fears develop automatically in every child and are not the result of parental threats or training, although they may be increased by such occurrences. The feelings are very painful, and the child tries to avoid doing anything that might cause them really to happen. This is why a child gets so frightened when he is about to be punished—he fears he may be punished by a mutilation; when he gets a slight wound, which indicates that more severe wounds can happen; or when he sees a mutilated person, for he is forced to realize that mutilation really does befall a human being. (In my experience, the last-mentioned type of dread is more frequent in girls than in boys.)

As the child passes from the prelatent period to the latent, he represses these fears into his unconscious, where they remain for the remainder of his life. If his instinctual desire—incestuous wishes toward the parent of the opposite sex, for which he dreads castration—are overly stimulated by either parent allowing himself to hold a less important position in the house than the child does, or if the child is prohibited too forcibly and too strictly from satisfying his infantile instinctual desires by prohibitions against finger sucking, masturbation, etc., his castration fears are accentuated. He finds it difficult to strike a balance that will permit him to obtain necessary instinctual gratifications in a socially acceptable way. He is forced to repress them too much and therefore, because of the repressed desires, is constantly apprehensive lest the punishment of castration fall on him. This apprehensiveness is felt consciously as anxiety and persists as an inordinate dread of punishment, inducing panic if his body is injured in any way and causing him to shut his eyes to anything that resembles a real mutilation. In cases, therefore, where the child has not been able to make an adequate adjustment to his castration fears, they remain a troublesome

intrapsychic problem against which he has to defend himself by various methods of defense—in some, like the patient, by denying that his body can ever suffer injury.

It should be remembered, particularly by the surgeon, that every human being has this unconscious castration dread, which is increased by any threat of bodily mutilation and therefore in the face of an operation or severe and disabling illness. A period of time must elapse after such an experience before an intrapsychic balance can be restored.

CASE 33. A well-adjusted woman, after her menopause had been established, had to undergo a hysterectomy. During the subsequent year she dreamed constantly, at first in a veiled and symbolic fashion and then more openly and directly, that she was pregnant. Also she became more and more interested in preparing and serving food to her family. Her dreams and her behavior accomplished the purpose of denying that the hysterectomy had taken place. Now a hysterectomy is actually a castration, though in this case the woman had already passed the child-bearing period. However, she reacted as if it had been a castration and attempted to quiet her apprehension by denying it had occurred. Of course she was able to accept the operation consciously, the denial taking place below the level of consciousness and thus influencing her behavior.

PSYCHOLOGICAL INVALIDISM

The second unrealistic attitude toward a physical illness is the opposite of the one just discussed. The child accepts all the restrictions placed on him quite peaceably; so much so that as he starts to recover he resists any attempt to remove them. He will not hear any encouragement to the effect that he is better and can do more now. Instead of recovering, he becomes a chronic invalid. When the situation is studied, it is found that he has learned that there are many benefits from being an invalid—extra attention, marked concern by his parents, extra food and toys, and frequent excuse from duties. Time and again I have referred to the strong secondary gains which the neurotic and the problem child obtain from their behavior, though the average person is no different from them in this respect. Once the child learns there are distinct benefits accruing to invalidism, he becomes loath to relinquish them even for the perhaps greater benefits of being well, since they require that he exert some effort. Indeed, frequently the child is aware of these secondary gains. However, most children who suffer from chronic invalidism are not aware that they are using their disability as a

means of gaining benefits; the mechanism is largely an unconscious one.

Behind the desire for secondary gains—conscious or unconscious—lies a deeper motive, of which the child is usually completely unconscious. It consists of two parts. First, he lives with unsolved intrapsychic conflicts. His unconscious sees the enforced illness as a possibility of castration. Unconsciously he feels that since this suffering and disability can happen to him, then worse sufferings and disabilities—i.e., castration—may be in store as a punishment for the forbidden desires in his intrapsychic conflict. In order to solve the conflict, he tries to remain ill in order to avoid the more terrible punishment. Second, in order to avoid the painful realization that he may have been injured—castrated—he tries to extract the greatest degree of pleasure possible from that state by glorying in the degree and extent of the injury. He libidinizes the state of being castrated.

CASE 34. A girl of seven broke her arm and shortly after began to glory in the fracture, the uselessness of the arm, and the pain. This is the well-recognized reaction that is found to a milder degree in adults, who seem to enjoy relating all the gruesome details of an operation. The child accepts the full extent of the physical disability because it makes him feel that he is superior for having it and because he finds that he receives more attention and is excused from onerous and uninteresting duties. These pleasure values in capitalizing on his disabilities may be conscious or unconscious, but deeper in his unconscious he gains more potent pleasure of a masochistic nature, of which he is totally unaware, from his fantasied castration.

The reaction to a physical disability by denial is frequently based on an earlier accentuated and unsolved castration fear. The reaction of chronic invalidism results more often from too much anxiety and concern for the child during his illness, particularly during his beginning convalescence. Both the parents' attitudes of overconcern and the child's reaction of chronic invalidism are difficult to change after they have become established and usually require intensive psychotherapy. For this reason prophylactic measures during the illness are extremely important. When a child develops an illness that is likely to result in a permanent disability, it is desirable to study his history in the light of possible traumatic situations that occurred during his life and particularly the attitudes of his parents before the illness began. If it shows definite neurotic symptoms to have been present before the illness, if he has experienced severe or frequent traumata, or if the parents' attitudes

have been adverse, he should undergo psychiatric treatment after recovering from the acute stage of the illness. If, on the other hand, it reveals no definite factors that would point to an incipient neurosis, the parents should be instructed in detail as to the nature and extent of the disability, the degree to which it will interfere with his future life, and particularly the degree of liberty of action he can have. I think it would be a good plan also to discuss these details with the child, and both child and parents should be encouraged to see that he begins to participate in the ordinary affairs of life as soon as possible and to the fullest extent advisable. Furthermore, the parents need to be encouraged to help the child to operate at the upper level of his capacity rather than to tell him what he is *unable* to do. And if the physician feels apprehensive in giving such encouragement lest the activity increase the organic disability, he need not feel so, since parents usually are quite apprehensive and will not follow his advice to the letter anyway.

Serious illnesses have different degrees of psychic effects at different stages of development. During the latency period (seven to ten years of age) and early adolescence they are likely to have the effects just described. During the prelatent period, the effects on the developing personality are frequently more severe but are less evident at the time.

OTHER PSYCHOLOGICAL EFFECTS OF ORGANIC ILLNESS

Physical illness may affect the personality in other ways than those we have been discussing. Severe attacks of infectious diseases in children and particularly in very young infants are fairly frequently complicated by some degree of encephalitis, which may result in permanent cerebral damage and which sometimes shows itself in changes in the character, often producing delinquency. Lurie and Levy,¹ among others, have reported similar results from the multiple cerebral hemorrhages that occur in severe cases of pertussis.

Freud² pointed out that a serious or long-continued gastrointestinal illness in early childhood frequently results in an irritable character that continues for the rest of the person's life. Schilder³ states that a serious

¹ L. A. Lurie and S. Levy: "Personality Changes and Behavior Disorders of Children Following Pertussis," *Journal of American Medical Association*, 120:800, 1942.

² Sigmund Freud: *Three Contributions to the Theory of Sex*, Nervous and Mental Disease Publishing Company, New York and Washington, 1930.

³ Paul Schilder: "The Concept of Hysteria," *American Journal of Psychiatry*, 95:1388, 1939.

or prolonged illness during the same period may result in the establishing of a pattern for dealing with difficult situations later on: if the individual who has undergone such an experience finds some difficulty of adjustment in adult life, he will tend to become ill as a means of solving his problem. Freud⁴ has stated that there is a type of adult personality who seems to have no feelings of guilt but behaves as if he could do anything he wanted, regardless of the objective consequences. Such a person, because he suffered from a very severe and painful illness in early childhood and was guiltless of any wrongdoing, feels he has paid the penalty for all future acts and therefore should not be expected to conform as other people must.

An illness that results in a permanent disability makes the individual inferior to his colleagues. This is more apparent in childhood, where physical competition plays a big role. The child recognizes his real inferiority and feels unhappy and discontented about it. In order to relieve these unpleasant feelings he is forced to develop compensatory achievements. These attempts at compensation occur in every case and cannot be regarded as pathological. However, they may or may not be adequate socially. Some children tend to compensate through undue indulgence in intellectual pursuits, others by becoming the ringleaders in antisocial activity; and in neither case, particularly if carried to an extreme degree, is the course very helpful to the child in his present or future social adjustment. I do not know why some children select personal or socially advantageous methods of compensation and some do not. Undoubtedly the selection is an unconscious one, but the dynamics have not been studied very extensively as yet. The ways in which parents encourage the child to compensate and the neighborhood standards as to what type of person is really important are important contributing factors.

The treatment for all of these various types of reactions to physical diseases is intensive psychotherapy to make the patient conscious of his unconscious conflicts and so relieve him of them. This is the treatment necessary for the patient in Case 32.

THE EFFECTS OF INTRAPSYCHIC CONFLICTS ON THE ORGANS OF THE BODY

Conversion hysteria is the illness whose symptoms lie most commonly in the physical field, and any case showing disturbance of physiological

⁴ Sigmund Freud: "Some Character Types Met with in Psychoanalytic Work," *Collected Papers*, Hogarth Press, London, 1934, Vol. IV.

function should be investigated *first* from the standpoint of conversion hysteria. However, it has long been known that intrapsychic conflicts can produce physical symptoms without the case being one of conversion hysteria, and it is only within recent years that there has been any scientific evaluation of the way in which psychic reactions affect the body. The work of Alexander,⁵ Saul,⁶ Dunbar,⁷ Weiss and English,⁸ and particularly the résumé by Fenichel⁹ has placed psychosomatic medicine on a more scientific basis. We now understand that a physical disturbance can result from a psychic conflict—usually an unconscious one—in the following ways:

1. When a person is angry, his muscles become tense in preparation for activity and his blood pressure rises. These bodily reactions are the somatic components of the state of being angry, and occur whether the person is conscious of his feeling of anger or, for intrapsychic reasons, is unwilling to allow himself to be conscious of the feeling. Thus he will have a disturbance of physiological function as a direct expression of his state of anger, but because of the intrapsychic conflict between his feelings of anger and his unwillingness to admit their existence, he remains unaware of the true cause of the muscle tension and of the increase in arterial pressure. He suffers from essential hypertension.

2. A physical change may always accompany a particular emotional state but instead of the emotional reaction appearing in the organ whose proper function it is, it may appear in an organ of a similar character. Sexual excitement causes engorgement of the erectile tissue of the genitals whether the person is conscious of the sexual excitement or not. In

⁵ Franz Alexander *et al.*: "The Influence of Psychological Factors upon Gastro-intestinal Disturbances: A Symposium," *Psychoanalytic Quarterly*, 3:501, 1934.

⁶ Leon Saul: "A Note on the Psychogenesis of Organic Symptoms," *Psychoanalytic Quarterly*, 4:476-483, 1935; "Incidental Observations on Pruritis," *Psychoanalytic Quarterly*, Vol. VII, No. 3, July, 1938; "Hostility in Cases of Essential Hypertension," *American Journal of Psychiatry*, Vol. 95, No. 6, May, 1939; "Some Observations on the Relations of Emotions and Allergy," *Psychosomatic Medicine*, Vol. III, No. 1, January, 1941; "The Emotional Settings of Some Attacks of Urticaria," *Psychosomatic Medicine*, Vol. III, No. 4, October, 1941; "Physiological Effects of Emotional Tension in J. McV. Hunt," *Personality and Behavior Disorders*, Vol. I, Chapter 8, Ronald Press, 1944.

⁷ Flanders Dunbar: *Emotions and Bodily Changes*, Columbia University Press, New York, 1938.

⁸ Edward Weiss and O. S. English: *Psychosomatic Medicine*, Saunders & Co., Philadelphia.

⁹ Otto Fenichel: "The Nature and Classification of So-called Psychosomatic Phenomena," *Psychoanalytic Quarterly*, 14:287, 1945.

the case that follows, not only was the person unconscious of the sexual excitement but there was no engorgement of the erectile tissue of the genitals. The engorgement was of the erectile tissue of the nose.

CASE 35. An unmarried male patient came to analysis for many distressing symptoms in his interpersonal relationships. During the analysis it was observed that he suffered from frequent head colds. When a close study of these colds was made, it was found that he invariably developed a severe cold when he visited his married sister, so that he was really quite ill throughout most of the visit. Although the colds were extremely annoying and caused him much suffering, he never consulted a doctor about them. Further analysis demonstrated that he had a very strong erotic attachment to his sister, who was considerably older and had taken care of him when he was a child. As a child she was his favorite, and he often fantasied and even said that when he grew up he would marry her. He was irritated when she married, and he changed from liking her to feeling sorry for her husband and being annoyed with her. This, however, was only a reaction against his erotic love for her which, because it was frustrated, he repressed into his unconscious. Still further analysis uncovered the realization that he had a tendency to develop an erection on anticipating his visits and during them, all of which embarrassed and shamed him and made him resolve not to let it happen again. From this time on, there was no genital excitation but he started to develop colds.

A penile erection is caused by an engorgement of blood in the cavernous tissue of the penis. The nose also contains cavernous tissue which, when engorged with blood, becomes considerably enlarged. (It is well known that a woman will often have nosebleeds at the time of menstruation—the engorgement of the uterine tissue being accompanied by an engorgement of the erectile tissue of the nose. A similar condition may occur in the male under the influence of sexual excitement.) The deliberate suppression of the engorgement of the erectile tissue of the penis which resulted from the man's unconscious sexual desires toward his sister caused the erectile nasal tissue to become more engorged. This congestion offered a fertile soil for the growth of the micro-organisms always present in the nose and also tended to occlude the openings of the sinuses. Since the nasal sinuses are constantly inhabited by micro-organisms whose degree of pathogenicity is low as long as the mucous membrane is healthy, the stoppage of free drainage from the sinuses produces an increase of intrasinal pressure resulting in a lowered resistance of the mucous membrane, and the organisms begin to flourish.

The end result of these two processes is a head cold. The patient did not seek treatment for his colds because he felt unconsciously that he should be punished for his unconscious incestuous desires. As the analysis continued, the patient concluded that he should consult an otolaryngologist. He did so and had the mild sinus infection cured. Now he no longer gets colds, his attitude toward his sister being that of a brother to a sister and not that of a disappointed lover for his sweetheart.

3. A physiological function may be disturbed because of an unsolved intrapsychic conflict. Saul¹⁰ has discussed this topic very adequately. He points out that psychogenic symptoms are not necessarily conversion symptoms but may be the result of organic disturbances that have been initiated by emotional disturbances. He cites the case of a man who presented a front of great independence and superiority. His behavior was the result of an attempt to solve his hurt pride, since he was really a very dependent person whose main aim in life was to get people to do things for him and give him things. During his analysis, these desires of which he had been unconscious became more conscious, appearing first in dreams of being fed and of aggressive biting. Then, he noticed that he would wake each morning with a mild sore throat or sore teeth. He consulted his dentist about the latter and was told that his teeth were inordinately worn down. On further inquiry, it was learned from his wife that during this time he frequently slept on his back with his mouth open and would waken her with the noisy grinding of his teeth. Further analysis revealed that while dreaming of being fed, he slept on his back with his mouth open. The breathing through the mouth and the throat position resulted in soreness of the mucous membranes and tiredness of the muscles of the throat; i.e., in a mild sore throat. When he had a dream of aggressive biting—as a result of his rage at being cut loose from his mother—he ground his teeth and so wore them down.

His behavior was an appropriate, direct expression of his emotional desires which appeared only in his sleep, and then in symbolic form. The behavior resulted in the organic dysfunction.

In another case, the patient complained of testicular pains, which were the result of the number of erections he had during sleep as the result of his unconscious incestuous fantasies.

4. A physiological function may be disturbed because of the attempt

¹⁰ Leon Saul: "A Note on the Psychogenesis of Organic Symptoms," *Psychoanalytic Quarterly*, 4:476-483, 1935.

to solve an intrapsychic conflict by regression. Alexander ¹¹ has pointed out that the human being seems to have three elemental tendencies: (1) to take in or receive; (2) to give out or eliminate; (3) to retain. Each of these tendencies may be found as modes of expression of either the erotic or the aggressive drives:

1. Desire to take in or receive
 - a. passive receiving (erotic)
 - b. aggressive taking (aggressive)
2. Desire to give out or eliminate
 - a. the giving of positive values such as making restitution or giving birth (erotic)
 - b. aggressive and sadistic elimination by attack or soiling (aggressive)
3. Desire to retain
 - a. friendly retaining (erotic)
 - b. hostile retaining (aggressive)

Ordinarily in adult life these elementary tendencies find their main avenues of expression through either the motor system or the sexual apparatus. However, if the use of these main avenues is inhibited by inner conflicts, the gastrointestinal tract becomes an especially suitable vehicle for their expression—since it was their main avenue of expression during the early years of childhood (the pregenital period).

The use of the gastrointestinal apparatus to express these tendencies interferes with its physiological function by throwing on the organs excessive work which, if long continued, can cause actual pathological changes in the organ, just as the continuance of essential hypertension can result in actual degenerative and nonreversible changes in the vessel walls. Gastric ulcer is a good illustration of this.

Gastric ulcer is caused by the gastric juices digesting dead or weakened tissue in the stomach wall. (The etiological factors that cause the death or weakening of these areas have always been obscure.) A series of such cases was subjected to analysis in order to determine the emotional status of the patient. In all cases the following picture was revealed:

The patient's conscious attitude was that he was a very independent, ambitious, and self-sufficient person. He had no desire to be helped by or to receive favors from anyone. He could always get along through his own endeavors. This attitude—an overexaggerated rejection of any

¹¹ Franz Alexander: "The Influence of Psychological Factors upon Gastrointestinal Disturbances," *Psychoanalytic Quarterly*, 3:501, 1934.

wish for dependency—overlaid marked wishes to be dependent, to be taken care of, to be given favors, and to be supported. It served as a denial of strong repressed desires to receive and to take from other people; i.e., repressed oral-receptive and oral-aggressive tendencies. Since they were repressed, their expression was removed from both the motor and sexual vehicles and was changed back to the infantile vehicle—i.e., the gastrointestinal tract—where the wish was converted into the original pattern, the wish to be fed and to eat.

The gastric activity was overstimulated because it received impulses from two sources: (1) ordinary hunger impulses; (2) the repressed strong psychic wishes to be fed and to eat. In brief, receptive and taking impulses were the content of the psychic stimuli that caused the overactivity, and this overactivity was the cause of the injury to the gastric mucosa.

There remains a great need for further research to corroborate these findings more certainly. There is a similar need for research along these lines in other organ diseases whose etiology is not very well understood at present.

All physicians should be aware of the contributions of psychiatrists and particularly of psychoanalysts to the understanding of the etiology of organic conditions whose etiology has been obscure. Such awareness, however, will not furnish them with the necessary tools for treatment, for the psychic conflicts that produce such severe organic results are usually unconscious ones and only by the technique of psychoanalysis can they be made conscious to the patient and so solved. The untrained physician who attempts psychotherapy in such cases runs the risk of making the illness, which now manifests itself as an organic disability, more serious: the patient may become psychotic.

The psychoanalyst, on the other hand, has to remember that a well-established organic change may be irreversible. If the patient has suffered from hypertension due to his unconscious conflicts for a long time, his increased blood pressure can have produced permanent changes in the arterial walls. Adequate therapy may solve his unconscious conflicts, but his blood pressure can continue to be elevated and his arteriosclerosis continue to spread.

muscles easily, her motions in cutting with scissors and in crayoning are quick and jerky. She is fairly active but does not have as much energy as many of the other children. In the middle of the morning she sometimes complains of being tired. She blinks and frowns frequently. Her oculist said her vision is not perfect but did not recommend glasses.

She eats fairly well and usually sleeps at naptime. She has to discuss at length the pros and cons of whether she should go to sleep. She urinates regularly four times during the day at school. She is not constipated but is very much aware of bowel movements. She rarely has one in school, but when she does she talks about its appearance, consistency, size, etc. She shows no signs of modesty. She tries to look up the teacher's skirt, saying in a teasing manner, "I can see your slip." She is co-operative and capable in all routine, liking to do such jobs as setting the table, washing the easel, and going to the store.

She adjusted to the group easily. After the first week, she began to play with some of the other little girls but paid little attention to the three boys in the group. She complains at home that the children do not let her play with them. At school she frequently refuses to let them play with her. She is not accepted by the older neighborhood children. At school she is the oldest child in the group and dislikes the younger children. She is not a leader but has a bossy manner when playing house. She likes to say who can play and what roles each should take. However, she plays co-operatively once she gets started.

She has a teasing, negative way of bidding for adult attention. She plucks at the teacher's skirt or hits her, saying, "I'm going to put dirt in your hair," or "I'm going to scribble all over your back." She thinks she is being funny and laughs uproariously while she teases. She always responds to the teacher's affection and always wants to sit next to her at lunch or story time. She does not show jealousy of the attention the teachers give the other children. She asks for help when she needs it but otherwise is quite independent.

Her special interest is in art work. She shows no restraint in using the materials and is not disturbed by nor overinterested in the "messiness" of clay and paint. Most of her work deals with objective things, and she seldom has a story to go with them. Among her paintings are a clock, a Christmas tree, designs, and people. Once she made a painting of her sister. She shows less imagination than most of the other children in the group, whose work she frequently imitates. She rarely volunteers to make up a song or a story.

She is interested in block building only when she can build with someone else. Her buildings are usually simple houses in which she and her playmates live. She enjoys domestic play and is the baby of the family or the nurse who takes temperatures and gives medicine to the baby.

She enjoys rhythms and music. In music she is beginning to help in making up songs. She enters into rhythms enthusiastically and is quite free in her movements.

She is an intelligent child and can follow directions well. She is inquisitive, asking many questions. Her vocabulary is good and she talks a great deal, although she stammers. Some days she stammers all the time and over every word. On other days she does not stammer much and only on the "and" of a compound sentence. Her tension—i.e., her jumping, waving hands, gritting her teeth, and clawing at things—usually does not coincide with her stammering.

She talks constantly of the crimes and murders she is going to commit. "Tomorrow I'm going to bring a gun and shoot one of the other girls, the principal, all the teachers and children except the ones in our group. If B. comes tomorrow, I'll shoot him, too." One day the principal visited her home. The patient had a wonderful time playing with her, chiefly in putting a clay hat on the principal's head. The next day she talked constantly of mutilating her, of cutting her throat and tickling her belly button. She talks often about excretory activities and composed a poem:

Un uh B.M. Wee Wee
Stick your head in pee pee
Stink Pot

Her school attendance is irregular: is absent frequently with colds or stomach upsets.

History. The patient was the older child in a family of two girls. Her conception had been planned and her mother was well during the pregnancy. Her birth was normal. She was breast-fed for two months. Her toilet training was completed without much difficulty when she was about eighteen months old. Following this she became constipated and was treated by means of enemas.

Her sister was more fond of the patient than the patient was of her. She showed no special jealousy of her sister and played with her when there was no one of her own age around. When there was, she had little time for her. At school she seldom mentioned her.

The mother had a "go and play" manner with the patient and did not

have much patience with her questions. She was a tense person, of which fact she was unaware.

The parents were reluctant to accept the school report that the patient showed neurotic symptoms. They did admit that she had a tendency to be overly conforming and was slightly tense, the tenseness having been present as early as four months of age, at which time they thought she waved her arms in a tense manner. Also, they stated that she stuttered slightly as soon as she began to talk. The father blamed himself for having been too harsh during her early training.

Examinations. Physical examination was negative except for a functional heart murmur, marked hyperkinesis which the physician stated was not chorea, vision, which was 15/20 in both eyes, and stammering. The doctor did not think there was any physical basis for her behavior.

The psychometric examination gave her a chronological age of 6-0, a mental age of 8-6 and an I.Q. of 142. Her memory was very superior. Her abstract thinking was very clear. Her answers to the similarities were precise and to the point. She enjoyed concrete problems. She concentrated well and was co-operative. She enjoyed the test very much but seemed tense and anxious, the tenseness increasing with the difficulty of the task.

The report of the Rorschach test was as follows. The patient was a very neurotic little girl, showing both compulsive and hysterical signs. Her serious lack of control might result in a psychopathic personality. Her inability to see the obvious and to think like other people might result in a schizoid condition during adolescence. There was, however, a good prognosis for normal development with proper care. Her intelligence was adequate, although the neurotic conflicts prevented her from concentrating. She had some capacity for organization but avoided the obvious and tended to jump to conclusions. She was egocentric and had a great craving for love and attention. During the test she was overactive and restless, did not follow instructions, and made constant requests for gifts of almost everything in the room. The test results showed strong unconscious hostility. There was already some superego development, not enough to form adequate inner control, but enough to add to her conflict and discomfort. The presence of both color and shading shock showed a deep fear of expressing emotion. Although she was an attractive child, her self-centeredness and the disciplinary problems she presented would make it difficult for people to like her, which would add to her isolation and insecurity. Much of her trouble related to her ambivalent feeling toward her mother, and possibly also toward her sister,

both of whom she consciously loved but unconsciously resented. Her restlessness and inability to concentrate would prevent successful work in school and thus add to her insecurity, unless her present patterns of behavior were modified and she learned to win love and approval in socially acceptable ways.

The psychiatrist found her an attractive little girl who was extremely timid. She stuttered at intervals, having difficulty in getting her words out. In the playroom she was extremely fearful lest she do something that her mother would consider dirty or bad. She had to ask permission each time she did anything. She first made a design with marbles. Then she drew a design on paper and seemed amazed that the back of the sheet of paper was dirty. After this she cleaned the blackboards. She proceeded to dig holes in the sand, stating that they were holes for moths to come from. She drew a number of faces on the blackboard, each one enclosed by lines that she called cages. These faces were of her father, her mother, a girl, a boy, her sister, and a boy with huge teeth. When I asked her who was the biter in her family, she said her sister bit often but did not if she left her alone. The main occupation of many interviews was her careful drawings of faces, each face having to be enclosed in a frame so that the enclosed person could not get out. She said she dreamed once that a brown snake was chasing her to bite her.

Throughout the interviews there was a complete denial of any reaction to her mother except staunch devotion. She expressed similar staunch devotion to her sister and would not admit that the sister (who was four years younger) was in any way less competent than she. In fact, she referred often to her sister's ability to do everything better than she did. She stated quite placidly that her sister was her father's favorite. Her behavior during the early interviews alternated between a precise overconformity and occasional outbursts of aggressive behavior.

Psychopathology. This little girl shows certain interesting reaction patterns. She is overconforming in order to keep her desires and impulses under extreme control. Hence she is constantly tense lest her controls break down and the impulses be liberated. She is usually unable to show imagination in her drawings: she prefers to draw designs or pictures that contain many design elements and that must be enclosed in frames. This is not the result of her training in art—as it might be in some children—because she has always attended a progressive school where the emphasis has been on absolute freedom of expression in all art work. They are limitations she has imposed on herself in order to avoid the fear she would feel if she tried to allow herself to be unre-

stricted. The same restrictions appear in her drawings of objects. All of the subjects in her pictures—whether inanimate or animate, but particularly the latter—have to be confined in cages. In short, all her impulses toward the various people whose pictures she drew have to be caged lest they do damage. In order to keep them caged—i.e., in her unconscious and divorced from her actual behavior—she has to behave and feel consciously in a way opposite to that which she feels unconsciously. In short, she utilizes the defense of reaction formation. There are times when the caging process and the defense of reaction formation break down, at which point her behavior is quite aggressive, attacking, and hostile. It is obvious that the impulses that must be caged are aggressive ones from the oral stage, oral-sadistic impulses, and that the caging of these impulses is responsible for her stuttering. She has to impose restrictions on her use of the mouth in speech lest she bite suddenly. Who is the object of her oral aggression—in other words, whom would she like to bite? She applies the strongest restrictions against aggressive impulses toward the mother and sister, restrictions so great that she tends consciously to idealize and overestimate them and states honestly that so far as she is conscious she does not feel any jealousy of the fact that the sister is the father's favorite.

Her next defense is regression. Her drawings reveal that her aggression is not of the phallic or anal stage but of the oral: she wants to bite and to hurt by biting. Although she repudiates this desire, she repudiates it less than she does her anal aggression—a desire to humiliate her rival by soiling and dirtying her; or her phallic aggression—a desire to kill and destroy her rival by using her hands. From both of these desires she has fled to the early infantile method of destruction by biting. Against the actual expression of this desire she has erected a series of secondary defenses: repression into the unconscious of her desire to bite and a strong conscious denial that such an impulse exists. The existence of these defenses raises two questions—why is her aggression so dangerous that it has to be guarded against, and why does she regress to the oral stage? She does not defend herself against aggressive impulses from fear of parental punishment as many children must do, for she has been punished only in the mildest manner. She needs her defenses because of the strength of her aggressive impulses. Their strength can be understood by rereading carefully the description of her behavior in school. She really has tried to hurt and soil others, even adults.

Some of the strength of her aggression may come from a congenital

endowment. She is hyperactive and, judging from the meager description her parents give, the hyperactivity has always been present. It is well known that babies differ in their activity in utero and that the hyperactivity continues after the child is born. Fries² has proved that at birth there are three types of babies—inactive, moderately active, and hyperactive. Our patient seems to belong to the last group. Hyperactivity and the aggressive impulse are associated because the latter uses the motor system as its main medium of expression. Of course, the hyperkinesis found on the physical examination of our patient may not be an innate hyperactivity but the result of emotional tension. (See Chapter VII.)

Some of the strength of the aggressive impulse may be a reaction to frustration. The patient has had two frustrating situations—one in her relation to her father, the other in her toilet training. Her father accuses himself of being stern, strict, and punitive toward her and of having placed strong emphasis on the necessity of obeying her mother and acting lovingly toward her. Therefore, being a girl, she would feel humiliated and angry at her father—her drawings show he is one of the people she would like to bite—feeling he had rejected her. Also she would feel extremely jealous of her mother but would have to repress this feeling and any expression of it in order to retain some degree of her father's favor.

Her toilet training seems to have been easy. She seems to have conformed rather suddenly; as a result, she became constipated. The mother, at her physician's advice, treated the condition with enemas, which would be pleasurable because they brought the mother's care and stimulated sensually the anal zone. On the other hand, they would make her feel completely frustrated, emptying her bowel whether she wished it or not. During toilet training the child first learns that he has power to control the actions of his own body and also that he has power in himself to resist or accede to his parents' wishes. The use of enemas denied all these experiences to this little girl. In addition they were painful and frightening; some of the pain may have had a basis in reality, but probably both the pain and fear were more the result of a psychic conflict between the child's desire to retain, manipulate, and obtain pleasure from her unrestricted anal functions and her desire to be a clean child and pleasing to her mother. She dreamed once that a brown snake was chasing her to bite her, a representation of anal

² Margaret Fries: "Psychosomatic Relationships between Mother and Child," *Psychosomatic Medicine*, 6:159, 1944.

aggression against the mother. It portrayed, too, a defense mechanism: the anal-sadistic snake was chasing *her*, instead of the mother. She turned the hostility against herself in order to protect the object of her hostility from destruction. The patient showed a further anal conflict: her enemas were pleasurable—even if some of the pleasure was unconscious—her wanting them shown by the continuance of the constipation. Furthermore her desire to have enemas meant to her a desire to remain a baby and dependent on the mother and would be in conflict with her desire to be grown up. Though such a conflict would normally not be acute in one so young, it is fairly acute in her case because she makes more marked demands for independence than is usually the case in a six-year-old.

Her behavior shows many evidences of an inadequately resolved anal-sadistic stage: she is very afraid of getting dirty; she emphasizes the need for meticulousness and orderliness—e.g., the balance of the designs. (Balanced designs also represent an attempt to balance “bad” impulses by “good” ones and vice versa—an illustration of the mechanism of undoing.) She insists on meticulously neat clothing, is devoted to drawing and coloring and is less interested in the many forms of play possible in the playroom. All of these reactions indicate that she has had to solve the problem of her anal eroticism mostly through the use of reaction formations, with attempts at only very restricted types of sublimation.

Her main developmental difficulty has centered in her toilet training, and a difficulty encountered at this stage is likely to be solved by a regression to the oral stage, which she shows. Sterba³ has shown that the child sometimes resists the toilet training by developing oral symptoms that can be removed only by stopping the training.

This patient has two main intrapsychic problems—her fear of her hostility to her mother and sister and her fear of her anal-sadistic impulses.

Diagnosis. The study of the patient's symptoms shows that they are those of an obsessional neurosis: she has great difficulty in making up her mind about what she wants to do—her indecision about her nap is a typical example of obsessional thinking; she is overly clean and meticulous, overly devoted and kind—typical examples of reaction formation; she turns her aggression from her mother and sister against herself; she has regressed from the phallic stage to the pregenital—oral

³ Editha Sterba: “An Important Factor in the Eating Disturbances of Childhood,” *Psychoanalytic Quarterly*, 10:365, 1942.

and anal—stages of development; she uses magical dreams to ward off danger.

THE PSYCHOPATHOLOGY OF OBSESSIONAL NEUROSIS

The obsessional neurosis has provided much interesting data concerning psychopathological mechanisms. Its psychopathology is more complicated than is that of hysteria. (For a more complete account of the psychopathology see Fenichel's ⁴ article.) The compulsive symptoms originate in a conflict over instinctual desires and express the conflict in a curious way: as a vacillation between the distorted representations of instinctual gratifications and the effectiveness of the repressing forces, which appear as self-punitive or expiatory actions. The methods of defense are more pronounced than appear in hysteria. The obsessional neurotic behaves as if he were a bad child and at the same time his stern parents—i.e., as if his personality were split in two, each symptom showing this biphasic character. This conflict is more internalized than in hysteria. The obsessional neurotic is conscious of many of his childhood memories which ordinarily do not appear in consciousness, but is not aware that there is any connection between them and his symptoms. Often instead of the conflict appearing as a symptom, he develops character traits whose purpose is to ward off the more direct expression of the instinctual urges. Thus obsessional neurosis differs from hysteria in that the patient is aware of the presence of offensive instinctual impulses but is not aware that his symptoms are defensive actions against them. In hysteria, the main defense lies in repression. In the obsessional neurosis the individual, meeting a real or fantasied fear of castration, protects himself from the danger by regressing psychologically to an older, more primitive method of thinking—in which thoughts are regarded as magical and omnipotent—to an earlier stage of partial narcissism, and to the anal-sadistic stage of libidinal development. Ordinarily, during this stage the child vacillates between his active and passive desires—i.e., his desire to love and to be loved—which desires are felt in the phallic stage of development as masculine and feminine. The obsessional neurotic, therefore, vacillates between his active masculine sadistic desires and his passive feminine masochistic ones. He develops reaction formations against both of these attitudes and from the reaction formation builds certain character traits.

⁴ Otto Fenichel: "Compulsion Neurosis—Outline of Clinical Psychoanalysis," *Psychoanalytic Quarterly*, 1:582, 1932.

In the obsessional neurosis, the ego is strong enough to make a vigorous protest against the demands of instinctual desires but too weak to meet the demands in that it adopts the most passive type of defense—regression. Obsessional neurotics show markedly the defense of isolation: by hard concentration on one subject, they will be able to keep themselves from thinking disturbing thoughts. They also show the defense of undoing by their penitential acts—making reparation for wrongs they would like to do—and in their rituals, by which they ward off or appease the disasters they fear. They also tend to sexualize their thinking. This process is rather typical of the child in the latency period, when he is trying to develop sublimations for his instinctual drives and at the same time to develop his intellectual abilities.

The patient we are discussing does not fit this description completely, for she is not a full-blown obsessional neurotic, standing, rather, at a parting of the ways. The path to normal adjustment is closed to her by her fears. She can choose between two other paths: (1) She may overcome her objections to her instinctual impulses and become a persistently naughty and aggressive child. Her environment, however, will dislike her aggressive naughtiness and attempt to stop it through punishment, which she will regard as a rejection, reacting by further hostility and aggression, and eventually perhaps becoming a delinquent. (2) She may choose the path of her defenses and, adding new ones of the typical obsessional type, become an obsessional neurotic. I would diagnose the patient as a pre-obsessional neurotic.

Freud⁵ originally maintained that the obsessional neurosis developed because of a sense of guilt about an active seduction of another person, while a hysterical neurosis developed in a person who was passive in the seduction. Later he abandoned this view, although it contained a large kernel of fact, since the obsessional neurosis is a defense against aggressive impulses. In the Rat Man, he⁶ showed clearly that the patient's problem lay in his inability to resolve his ambivalence to his father because of tremendous overt hostility to him, feeling that the increase in hostility was due to the father's restrictive attitude toward his small son's sexuality as expressed in masturbation. Undoubtedly, many cases of obsessional neurosis are caused in this way. However, I have seen a number of cases where the cause did not seem to lie so much in the

⁵ Sigmund Freud: "The Defense Neuropsychosis," *Collected Papers*, International Psychoanalytic Press, London, 1924, Vol. VIII, p. 164.

⁶ Sigmund Freud: "Notes upon a Case of Obsessional Neurosis," *Collected Papers*, Hogarth Press, London, 1933, Vol. III, p. 296.

difficulty with hostility aroused by actual frustration of infantile sexuality as by frustration in the parent-child relationship. If either parent, but particularly the parent of the opposite sex, rejects the child, he becomes very hostile and aggressive and develops a chronic aggressive character pattern. If after this character pattern has developed, some change that makes life more livable for the child, such as placement in an institution or foster home, is made in the environmental situation, the child may respond suddenly to the changed environment. Almost at once he will begin to build up obsessional defenses against the accentuated aggressive impulses, which defenses are in the nature of reaction formations. I have discussed this course of development elsewhere.⁷

There must be a difference in the types of obsessional neurosis resulting from these two different etiological factors. The type described by Freud always has a core of hysterical repression underlying the obsessional mechanisms and therefore should be more amenable to psychoanalytic therapy. The type I mention does not have an underlying core of hysterical repression but is based on a different personality structure. I will discuss this type of personality structure later, when we come to the character neuroses, particularly those showing a chronic aggressive character pattern. The underlying difficulty is a fear of loving which starts very early in infancy as a result of the parents' rejective attitude. Treatment, therefore, will have to deal not only with the removal of the obsessional defenses against aggression but also with the removal of the more fundamental defenses against loving. Many psychoanalysts, including myself, are of the opinion that cure in the obsessional neurosis is very difficult to obtain and requires a prolonged analysis whose end results are not so good as in hysteria.

Prognosis. The prognosis for our patient is good. The obsessional defenses are not firmly entrenched, and the parental attitudes are for the most part healthy.

Treatment. Treatment will depend on the knowledge of the patient's problems. As we have seen, they are fear of her aggressive feelings toward her mother and sister, and fear of her anal and oral impulses. Her defenses were erected against these impulses and became unnecessarily strong because of her fears that the objects of her hostility had similar or even more powerful impulses toward her and that her impulses really could destroy their objects. Treatment will be directed

⁷ G. H. J. Pearson: "The Chronically Aggressive Child," *Psychoanalytic Review*, 25:485, 1939.

toward making her less afraid of her own impulses by making her aware of them and so putting them more under her control. This can be accomplished in one of two ways. First, a group experience is often effective. Through contact with children of his own age and under the guidance of a sensible adult leader, a child can learn that hostile and aggressive impulses are part of everyone's nature and that they are useful for success socially and vocationally. Also, he can learn that cleanliness and order do not equal godliness, and that his desires to be dirty can be gratified in a culturally accepted manner. The group method was tried with our patient with not too much success. If there had been a more accurate recognition of the problems involved, the use of group therapy in school would have helped more. As a general rule, group therapy does not cure a developed obsessional neurosis or even one where the trend toward the development of such a neurosis is clear. It can have value for the very small child—i.e., between two and four years of age—to prevent the beginnings of obsessional mechanisms. More efficacious and more desirable would be the second method—intensive psychotherapy, which was the one used in this case and with a good result. Interestingly enough, the major method of treatment was through the use of painting and drawing. Attention was centered on replacing the designs by free pictures and getting the figures out of their cages and the free pictures out of their frames.

THE PREVENTION OF OBSESSIONAL NEUROSES

I am postponing the fuller discussion of treatment methods to a later chapter. Here it is only important to discuss the question of whether the patient's obsessional neurosis could have been prevented. This question is very important from the point of view of the mental health of the community and points up the responsibilities of the general practitioner and pediatrician. One child becomes neurotic seemingly because of the effects of certain environmental experiences. Would another child become neurotic if he were placed in exactly the same circumstances? In short, are there certain constitutional factors that predispose an individual to neurosis? This is a question that is extremely difficult to answer conclusively and that cannot be proved experimentally because no two human relationships are exactly the same and no parent can feel or act exactly the same toward each child. It must be said that although many neurotic children have neurotic parents, this does not mean necessarily that the child inherits a predisposition to a neurosis;

any child would have difficulty adjusting to the environmental situations produced by neurotic parents. However, there does seem to be a valid basis for the speculation that certain people have a constitutional tendency to become fixated on a particular erogenous zone: in some families the oral zone seems to be highly endowed, in some the anal, in others the urethral (enuresis seems to run in families). This fixation makes it more difficult for the individual to give up the primacy of the zone and subordinate it to the primacy of the genital. He is more difficult to train in toilet habits, or has greater difficulty relinquishing finger sucking, etc. However, this discussion at present remains speculative, so it is better for the physician to disregard the question of constitution until he has excluded every possible environmental influence.

Our patient did have some difficulty over toilet training: rather than fight the training, she succumbed too quickly and as a result became constipated. For this condition she was given enemas. Enemas and suppositories stimulate the sensory areas of the anus and the adjacent parts and as a result give sensual pleasure. This accentuation of sensual pleasure makes it difficult for the small child to relinquish his anal eroticism, because he wants as much pleasure as he can possibly get. If the parents stop the enemas, the child again becomes constipated in order to insure a continuation of the pleasure. If the enemas are not forthcoming, the child resorts to self-stimulation of the anus. Also he becomes very angry toward the parents, and more so if they forbid the anal touching. All of this complex of emotional reactions and desires results in his attention and interest remaining fixed on the anal zone. Although he wants somehow to grow up and become cultured, he will have to exert extra efforts to repress this interest, and much of his psychic energy will remain bound in the process of keeping his anal interests repressed. All of this results in a weakening of his ability to progress to the next stage of development—i.e., a fixation, a tendency to regress to anal interests—either directly consciously or in the form of reaction formations and a great lack of capacity to use his anal eroticism in sublimated ways whenever new psychic difficulties are encountered. For these reasons it seems to me inadvisable to treat a child with enemas or suppositories before the latency period is established, unless absolutely necessary. I do not know under what circumstances they are ever absolutely necessary. This is one prophylactic measure of importance.

Our patient succumbed too readily to toilet training. The mother, instead of feeling delighted at this, should have felt some concern. It was wrong to give the child the impression that cleanliness and dryness are

the most important virtues in life. It would have been better to have provided materials for sublimation of the anal-erotic impulses—clay, mud and water for mud pies, finger paints, etc., and to have permitted the child to indulge in these activities for a longer period than might be customary. There should be little emphasis placed on cleanliness during the early years of his life.

THE CHILD WHO IS INTELLECTUALLY RETARDED

A CHILD who is intellectually retarded is one who basically is less intellectually capable than the average child. Clinically there are three levels of retardation.

1. Idiocy—the I.Q. is below 25. Such individuals are usually incapable of protecting themselves from the ordinary dangers of life.

2. Imbecility—the I.Q. is between 25 and 60. Such individuals are usually not capable of becoming self-supporting.

3. Backwardness—the I.Q. is between 60 and 90. Such individuals are capable of becoming self-supporting, but usually have difficulty in progressing in school beyond the beginning of high school.

CASE 37. A girl of thirteen is referred by her parents because she has difficulty with schoolwork and occasionally has an epileptic convulsion. She is left-handed, her co-ordination is poor, and she is sloppy in her habits. She is an adopted child. She is dictatorial toward her father but seems emotionally dependent on her parents. She does not cultivate friendships with other girls, although between eight and eleven she was devoted to a girl three years older.

History. She was adopted at the age of six weeks and seemed a normal baby. There was no feeding difficulty. She started to walk at fourteen months but did not begin to talk until she was three. Her mother had no difficulty in her toilet training. She became dry in the daytime at eighteen months and dry at night at three years, although she still wets occasionally if she becomes excited. When she was two and a half, she

had a short series of convulsions, which recurred at six and a half, between seven and eight, and between eleven and twelve. She sucked her fingers until she was four years old, when it was stopped by bandaging her fingers and shaming her. The finger sucking was replaced by nail biting and nose picking. She had a moderately severe attack of pertussis when she was nineteen months old, chicken pox at nine, and measles at twelve.

Examinations. Physical examination revealed no signs of organic disease.

Electroencephalogram: There were showers of slow abnormal six and seven-per-second waves seen throughout both hemispheres, indicative of underlying cortical changes. The abnormality was minimal to moderate in degree. Following hyperpnea, large, slow, abnormal three and four-per-second waves and spike wave formations appeared throughout both hemispheres. There was no electrical evidence of a focal lesion. The electroencephalographer believed that these changes were of the type usually associated with convulsive disorders but that their etiology would have to be determined by the clinical findings.

The psychologist¹ reported that "she had a pleasant manner and was thoroughly co-operative during the examination. At the same time she was distinctly childish in her affect patterns and obviously dull in all her reactions. Qualitatively she seemed definitely subnormal to the degree of even mental deficiency. She had a veneer of normality in ordinary conversation or casual matters. When anything more than the merely casual was demanded, it was very clear that her capacities for understanding things and for reacting to situations demanding the integration of a complexity of mental powers were very weak. The test results were as follows:

<i>Stanford-Binet Scale:</i>	(1916)
Mental Age	8-4
I.Q.	61

On the Stanford-Binet examination it was necessary to go back to Year VI in order to establish the basal age, for the girl failed even on the simple differences items among the seven-year tests. Her output on all the items at Year VIII was not very good, but still it was possible to give credit for five out of six of them. At Year IX one-half the items were passed, but credit could be given for only one at Year X. There was miserable failure on all the items at Year XII.

¹ I am indebted to Dr. George Carl for the careful psychometric reports in this chapter.

Chicago Nonverbal Examination

Mental Age	7-5
I.Q.	54

Thorndike-McCall Reading Scale

Reading Age	8-8
Reading Quotient	63
Reading Grade	3.5 (5th month of 4th school grade)

Kohs Block Design Test

Mental Age	6-3
I.Q.	46

Healy Pictorial Completion, II

Score	26.5 points
Rating	exact score of 8 year median.

The psychometric data themselves, interpreted in conventional fashion, constitute the most significant things on which over-all diagnosis may be based. It will be observed that the Binet rating is substantially higher than that on the other tests, except on the Thorndike-McCall Reading Scale. Both these results are spuriously high in one sense of the term; it seems that the girl's abilities—in contrast with her basic capacities—have been somewhat 'hothouse'd' in certain formal ways. The over-all picture is more nearly one of high-grade imbecility, as implied in the Chicago and Kohs results, than it is of high-grade feeble-mindedness, indicated in the Binet results. This point, of course, may be of special importance in making plans for the future—particularly in respect to certain procedures to be followed in connection with schoolwork."

The psychiatrist observed that she was a pretty, nicely dressed, attractive, responsive girl who did not impress him as being feeble-minded. She stated that she had trouble with her mother but none with her father. She disliked boys.

It should be remembered that not all children who appear stupid are intellectually retarded. On psychometric examination, their I.Q. may be average or above average. Therefore, no diagnosis of intellectual retardation should be made without a psychometric examination by a competent psychologist. The careful wording of the psychometric report in this case is worthy of study. It indicates that the psychologist is well aware of another possibility; not all children whose I.Q. on testing is below 90 are necessarily to be diagnosed as suffering from intellectual retardation. The apparent lowness of the I.Q. in some may be

due to a withdrawal from reality or may be the result of severe emotional blocking. In the first instance the child is psychotic; in the second he is suffering from a severe psychoneurosis. I have reported such a case,² and many other observers have reported similar ones. However, the intellectual retardation in this case is real.

Etiology. Besides the intellectual retardation, she suffers from occasional attacks of convulsive seizures, and her electroencephalogram shows a pattern somewhat typical of a convulsive state. (I have stated previously that the electroencephalogram is not a reliable diagnostic method in children. However, children that have convulsive seizures show an electroencephalogram similar to that of adult epileptics, which is believed to be pathognomonic of the epileptic state, and so such an electroencephalogram is an important aid in the diagnosis of epilepsy for all age groups.) The combination of the retardation, the history of convulsions, and the electroencephalogram indicates that the child has suffered cortical damage. Neither the history nor the physical examinations are adequate to determine the etiological factor for the cerebral damage, but speculatively it seems probable that she had a diffuse cortical injury as the result of some birth trauma.

THE CAUSES OF INTELLECTUAL RETARDATION

Intellectual retardation may result from several causes:

1. A small percentage of such cases are due to defective germ plasm, which results from the union of two constitutionally intellectually defective persons or from a union one partner of which has a dominant trait that leads to defective intellectual development.

2. Severe diseases of the mother during pregnancy may result in defective development of the fetus. Examples of these are marked starvation, which may often result from the pernicious vomiting of pregnancy; avitaminosis; infections either acute or chronic, as tuberculosis and syphilis; the chronic degenerative diseases such as nephritis and diabetes (both of which may liberate chemical toxins); or endocrine deficiencies such as hypothyroidism.

3. Birth injuries: a too short or too prolonged labor may cause excessive hemorrhage in the brain or cerebral anoxia with destruction of cortical cells, which are able to live only an infinitesimal time in the absence of oxygen. Such birth injuries may be common, although they

² Gerald H. J. Pearson: "A Case of Compulsion Neurosis in an Eleven Year Old Boy," *American Journal of Orthopsychiatry*, 10:136, 1940.

may produce only minor neurological signs, or even none that can be detected clinically.

4. A congenital absence or hypodevelopment of the thyroid. This is the familiar condition known as cretinism.

5. Vitamin deficiency in the first year of life. Rachitic children often show intellectual retardation, the vitamin deficiency impairing the development of the cortical cells.

6. Postnatal cerebral insult from head injury.

7. Infectious diseases in early infancy. Any infectious disease—scarlet fever, measles, chickenpox, meningitis, epidemic encephalitis, syphilis, tuberculosis—may be complicated by an encephalitis which destroys large numbers of the cortical cells. Pertussis, which may cause massive or multiple minute hemorrhages in the brain, is an important cause of intellectual retardation, as Lurie and Levy and others³ have reported.⁴

8. Isolation: Wasserman⁵ wrote a story that well illustrates this etiological factor. If a child is inordinately isolated from contact with all other human beings during his early years, he will suffer from a lack of the emotional and intellectual stimulation which is necessary for the proper development of the psyche and of the intellect, as Freud and Burlingham⁶ and Ribble,⁷ among many others, have reported.

A very much higher percentage of cases of intellectual retardation are due to causes 2 to 7 than to cause 1, although popular opinion believes differently. Since intellectual retardation not due to inherited causes cannot be transmitted to the offspring, the question often raised as to whether feeble-minded persons should be sterilized can be answered only by the statement that in each case a proper diagnosis of the etiology of the intellectual retardation would have to be made. Of course, there

³ L. A. Lurie and S. Levy: "Personality Changes and Behavior Disorders of Children following Pertussis; Report Based on Study of 500 Problem Children," *J.A.M.A.*, 120:890-894, November 2, 1942. H. Roger and M. Schacter-Nancy: "Les Complications nerveuses de la coqueluche," *Marseille-méd.*, 11:171-190, February 5, 1939. M. Schacter-Nancy: "Complicaciones y secuelas neuro-psíquicas de la tos convulsa," *Arch. de Pediat. d. Uruguay*, 9:724-729, December, 1938.

⁴ Behavior changes which may follow pertussis or an infectious illness complicated by encephalitis are not always the result of an intellectual retardation as a sequela of the disease. Frequently there is no change in the intellectual capacity. I will discuss cases of this type in Chapter XIV.

⁵ Jacob Wasserman: *Casper Hauser*, Liveright, New York, 1928.

⁶ Anna Freud and Dorothy Burlingham: *Infants without Families*, International University Press, New York, 1944.

⁷ Margaret A. Ribble: *The Rights of Infants*, Columbia University Press, New York, 1943.

is the question as to the type of parent such a person would make, but even here the decision must be made on the individual case.

THE DIAGNOSIS OF INTELLECTUAL RETARDATION

The diagnosis of intellectual retardation in children is best made by the use of psychometric tests (see Chapter II). The tests should be given by a psychologist experienced in testing individual children, who understands well the problem of interpersonal relationships and their influence on the testing situation and test results. In the case under discussion, the question as to whether the child is intellectually retarded is clear-cut. In other cases, the diagnosis is not easily made.

PSEUDO RETARDATION

There are a number of children who because of their actions appear to be intellectually retarded but who on psychometric examination are found to be average or better. The psychologist's report of such a case follows:

CASE 38. "The boy began his work with me in a slightly hesitant manner, but very soon gained normal poise and co-operated quite well. Conversational output was definitely on the good side, and no 'nervous' mannerisms asserted themselves in the early, informal part of the examination. Generally speaking, the impression I gained from this phase of our work was that the child was normally bright, albeit a bit 'unusual' in many of his reaction patterns. However, as the test progressed, and we got down to 'brass tacks' in our work on various tests of function, a very considerable change took place in his behavior. Although his co-operation remained essentially good, marked restlessness developed. He squirmed a great deal, became overactive, and seemed unable to give more than momentary attention to a task. This kind of behavior occurred principally when the task to be done was a fairly difficult one, but it occurred also in many cases where the test was easily within the boy's powers of comprehension. In sharp contrast with somewhat similar behavior often observed among subnormal children, the boy's distractibility was not of the 'vacuous' kind, but always seemed to represent a simple transfer of attention from one thing to something similar. The waywardness of attention was accompanied by marked motor in-coordination. With no signs of such difficulty at the beginning of the session, the situation developed to the point where the boy was dropping

and retrieving his pencil from under the desk at least once a minute. From a purely psychometric point of view, the most prominent feature of the situation was the markedly erratic intellectual function. Not only was this disclosed in the tremendous variation among the test results, but equally so by consideration of the separate performance on each scale. Time after time he did something with supreme ease only to bog down completely immediately afterward on an equally simple or difficult test item of the very same kind. This tendency increased as the test proceeded. Even on the Binet examination there were marked inconsistencies. Rote memory—on the digit span items—turned out to be excellent. In spite of the fact that he appeared to have a very good command of language, his work on the vocabulary items turned out to be very spotty—some excellent, some very poor. On the Chicago Nonverbal Examination his easy and good output would be followed immediately by almost complete blocking or confusion. On the Kohs Test I had to work hard to develop his comprehension of the very simple trial exercise, which is usually understood even by six-year-old children without much explanation. Eventually he caught on completely, giving me back spontaneously an accurate explanation of what was to be done, but within one minute it was apparent that his understanding of the matter had deserted him completely, and he realized almost no success with the test items which counted in the scoring.

"The actual test results were as follows:

<i>Stanford-Binet Scale</i>		(1916)
Mental Age		9-9
I.Q.		91
<i>Thorndike-McCall Reading Scale</i>		
Reading Age		10-5
Reading Quotient		98
Reading Grade		4.8 (8th month of 4th school grade)
<i>Chicago Nonverbal Examination</i>		
Mental Age		6-7
I.Q.		62
<i>Kohs Block Designs Test</i>		
Mental Age		5-7
I.Q.		52

"His behavior as recorded in his early years was as follows: At the age of four to five months he kicked his legs at random, sat when

propped up, and seemed very little concerned with his surroundings.

"At the age of ten and a half months he could not sit up and could only hold up his head. He had to be stimulated for any activity. He could close and open his hands and could roll over.

"At the age of fourteen months he kicked, played with his pillows, and reached for his toys. He could barely creep but could stand with support and could sit up unaided.

"At the age of two years he could creep and go up a few stairs unaided, could get on his feet by pulling himself up, and could walk a few steps unsteadily by holding on.

"As a young baby, he was not expected to live. He ate poorly, suffered from spasmophilia, developed rickets, and was subject to constant severe upper respiratory infections. His vision was quite defective, and he had fine nystagmoid movements of both eyes. His muscular coordination for both small and large movements was poor."

The psychologist considered his basic (quantitative) intellectual endowment to be of normal caliber—perhaps somewhat better.

CASE 39. A girl of five acted in many ways like a much younger child. When picking up a toy, she would look at it and then smell it very carefully. This behavior resulted from extremely poor vision. She had been born with congenital cataract and glaucoma of the left eye, and only recently and as the result of a number of operations was she able to see at all.

Her psychometric report showed that she was intellectually retarded three years because of her blindness. Up to this time her physician had refused to allow any psychometric evaluation to be made because he felt it would be unfair to the child. Her eyes were not sufficiently good to do "block" work. He felt the child showed adequate reasoning and was able to follow directions when not confused by poor visual impressions.

The importance of the use of smell, which disappears very early in children, had been retained by this child as a compensation for her defective vision.

PSEUDO RETARDATION DUE TO PSYCHOSES OR SEVERE NEUROSES

Any severe sense of deprivation or the isolation and restriction that are a part of frequent or prolonged illnesses in infancy will retard the child's intellectual development and so produce behavior resembling

true intellectual retardation. Such cases can be diagnosed by the psychometric examination.

There are children whose behavior and psychometric examination show intellectual retardation. However, on close study it is found that the retardation is due not to a retardation of cortical development or a cortical insult but to a psychosis or a severe compulsion neurosis. The intrapsychic process is one that causes the ego and all its functions, among which is intellectual capacity, to disregard reality, which makes it impossible for the child to develop the use of his intellectual functions. In my opinion such cases occur more frequently than is commonly believed and are diagnosed as feeble-mindedness. The true diagnosis is difficult to make but should be made on the basis of the peculiarity of the behavior and of the test results. The latter is well illustrated by the psychologist's report on the following case.

CASE 40. A girl of six was brought by her father for a psychometric examination, during which the father had to help the psychologist with the test because she was un-co-operative.

"With the child so nonreactive to nearly all kinds of stimuli, I naturally found it very difficult to administer even a simple psychometric test with any degree of satisfaction. For instance, with the very easy series of formboards (three discs, three circles and three figures) there was either no reaction or aimless reaction nearly all of the time. However, every now and then there was a perfectly normal and satisfactory performance, even on things which, both before and after, seemed to be completely beyond the child's comprehension. The same was true of the little girl's output on the Binet items. Cajoling, pleasantries, even sternness, brought forth nothing whatever. Yet if the child could be caught 'on the wing,' a thoroughly satisfactory and comprehending reaction could be secured. Thus I am well satisfied that the Mental Age rating of only 3-2 (I.Q. 66) probably does not represent the child's intellectual potentials. On the other hand, it is quite likely that the patient often, if not usually, functions at even a level lower than that just indicated, for it is most unlikely that she is presented with stimuli in her everyday life with the same persistence and patience employed by her father and me in this examination. There was virtually no spontaneity in any of the reactions. It was possible to secure, occasionally, what might be called 'chain' reactions—a perseveration; i.e., simple vocal productions carried from one task to the next. Echolalia was most pronounced. Even such simple questions as 'What is your name?' and

'How old are you?' usually elicited the responses 'your name' or 'old are you.' In both the instances just mentioned, the child gave the right answers after a while.

"The father provided the information necessary for administration of the Vineland Social Maturity Scale. Here again the element of non-reactivity puts a large burden on the scoring, with the result that the total rating is subject to question in much the same fashion as in Binet. However, the actual quantitative result is almost identical with that on Binet—a Social Age equivalent of 3-1 with a corresponding S.Q. of about 65. In my opinion, the patient showed evidence of functional disability at a level of mental deficiency outside of purely intellectual things. Over a period of years I have seen quite a few very young children who had characteristics much like this and whose difficulties later turned out to be those of abnormality—in some cases, actual juvenile psychosis—rather than of mental deficiency.

"Her patterns of behavior were not the conventional ones of negativism or stubbornness, but rather those of utter placidness and detachment. When the patient seemed in this condition of apathy there was lacking the usual aura of stupidity or mental deficiency. The impression gained from observation of her behavior was that there was a psychopathological indifference to most kinds of stimuli rather than deficiency in the basic intellectual tools.

"Considered from a purely psychometric point of view, the situation was one of marked disability, sufficient to warrant classification as a case of actual high-grade feeble-mindedness. The validity and reliability of the test scores can be questioned seriously as indices of this child's actual intellectual capacities. There was not a single thing in the developmental history through the stages of learning to walk and to talk which fitted any conventional patterns of infants. The health history was strikingly negative for all of the usual causative factors contributing to secondary amentia. The neurological studies apparently revealed nothing out of the ordinary. Thus, while it would be impossible to deny a tremendous retardation (delay or blocking) in many aspects of psychological development, I am pretty thoroughly convinced that the true condition is more one of abnormality than of subnormality."

Here is another case whose clinical picture seems to be intermediate between Cases 38 and 39 and Case 40.

CASE 41. A thirteen-year-old boy was referred because he had no interest in his schoolwork, daydreaming instead. This was so marked that

the teachers thought he was deaf. His behavior was good and he was not mischievous. He failed of promotion four times—in the second, third, fifth, and sixth grades.

When he was six years old, the psychological department of the school system made the following report: The patient was the second boy in a family of three. His father was Jewish, his mother Irish. The latter had poor health. She stated that all her children were problems and had got on her nerves. She was much concerned about the children and tried to keep them clean and to feed them properly but was incapable of training them. The boys particularly were disobedient and irresponsible, though the elder had improved lately. No punishment, whether deprivation or spanking—which she had used too frequently—had been effective.

The patient entered 1-A from kindergarten. His teacher reported he would arrive late—sometimes as late as 10:30—and that he would stand at his desk when the other children were seated. Frequently he called out answers for other children. He kept his coat on unless reminded to take it off. He played constantly. In general, he refused to conform to schoolroom regulations. He paid attention only when reading or holding the center of the stage. At other times he was distractible. He had made some scholastic progress. He was not popular with the other children. One day at lunchtime he attracted awed attention by chewing on a tin bottle top until the blood ran from his mouth.

History. He had been a healthy baby. At eighteen months he suffered severe shock and an injury requiring four stitches, when the register of the pipeless heater in the ceiling fell upon him during his sleep. He had always been restless and had twitching movements of the mouth, the symptoms having increased since the age of five, when he had chicken pox. Shortly before this examination he had been studied by the family physician because of masturbation, and the doctor had advised the mother to give him more freedom during playtime and to cease her constant nagging.

Examinations. Except for 15/20 vision in each eye, his physical examination revealed no defects.

The psychologist reported that the patient was infantile in appearance and in orientation. Test results showed an I.Q. of 93. His competencies were adequate for first-grade learning. His work with performance tests was uneven. With the Witmer Formboard—a test at the four-year level—his scores compared with the poorest 10 percent of six-year-old pupils;

with the Witmer Cylinders, a complex intelligence test for his age level, his work compared with a group superior to 60 percent and inferior to 30 percent; his memory span fell below the median group. It was the psychologist's opinion that he would never produce a consistently stable type of school performance and that he would need special interest and direction. Good teaching and real effort on his part were responsible for his having learned to read and spell during his first year in school in spite of poor emotional responses and physical strain.

At the age of nine he was examined again by the psychological department of the school system. His mother reported that he behaved more satisfactorily but that he seemed to lack energy. He did not talk much, and his speech was slow and was poorer than that of his younger sister of five. He needed help to tie his shoes and button his clothes. His mother said he claimed that school was too hard for him and that he got mixed up in his work. She thought he had been more punctual. Since the previous examination he had repeated the 2-B and 3-A grades. His teacher thought he was worse now. He would lie on the floor, pretending to be asleep. He received a satisfactory mark in reading. The psychologist reported that he seemed immature, indifferent, and lacking in motivation. It was difficult to get any response from him. He wiggled continually. Though there was fairly good rapport, there was no active co-operation. He seemed to be afraid of failing, so he would not attempt to guess. It was evident that he had more ability than he used. The psychologist felt that the I.Q. of 89 he obtained was too high. The only ability he revealed was his reading skill—he read for pleasure, got satisfaction from it, felt adequate about it, and read up to grade with comprehension. He was weak in number work, disliked figures, and worked only when supervised. His writing was painfully slow and his spelling no better than a weak 2-A grade.

A similar examination was conducted when he was eleven. At that time his problem was stated to be nonconformity in behavior. He was constantly late for school and at times un-co-operative in the classroom, often refusing to make any response. He presented much the same picture as described in the earlier psychological reports. He was silent and noncommittal. He showed distress in breathing. His nose was stopped up. He sighed. He breathed heavily and yawned excessively. His muscular co-ordination was poor. He was extremely slow in such motor activities as writing, making a design, etc. His finger movements were jerky. He displayed nervous mannerisms—constantly pulling and

twisting at the sleeve of his blouse—and his body twitched and jerked. His I.Q. was lower—85. Each psychological examination showed a lower I.Q.—93, 89, and now 85. He showed a definite limitation in vocabulary and other language ability. Qualitatively his responses were poor and seemed lacking in motivation. His memory span was slightly improved but still short. His working span was even less, requiring constant direction, stimulation, and supervision. Otherwise he did nothing but gaze about, thrusting his left arm over the back of the chair and jerking, twisting and wiggling constantly. He was given number work to do. Even though his attention was called back to his work he seemed not to be able to remain at it any length of time. He played with the pencil, gazed about, showed difficulty and lack of skill in making the numbers. He could not compete against time, of which he seemed to have little concept. Here are two typical examples of his speed: He was asked to name as many words as he could in one minute. The usual score is 28; his was 10. The seconds between words were 3, 5, 7, 9, 5, 3, 6, 12. When he was told that he could return to his classroom, he stopped on the way to the door and examined pictures on the wall.

When he was thirteen the examination was repeated, his teacher stating that his co-operation was fairly good, although he did play in class, do very little work, and refuse to copy work from the board. The psychologist reported that he seemed very restless at the beginning of the examination, moving his hands constantly, and frequently placing them at his mouth in apprehensive gestures. He sighed frequently and pursed his lips. He did not look well. On the tests he showed the same degree of ability as formerly. His speed of response was better. He named twenty words in a minute, as contrasted to the ten words previously. He also completed a reading test within the time limit.

On the Binet Scale, his performance ranged from the nine-year level—the highest level at which he was able to pass all tests—to one isolated success at both thirteen- and fourteen-year levels. He displayed vocabulary limitations and lacked complexity in functioning. He failed on tests requiring the use of classifications and on language-completion tests, but passed the arithmetical induction test at the fourteen-year level. He was able to pass the visual imagery tests at the thirteen-year level. He was given written work, spelling and arithmetic. He voiced no objection but seemed to find it difficult to restrain his wiggling and force himself to the control the work demanded. His handwriting was immature and his range of information restricted. He had a few simple concepts in social studies but did not know what his class was studying.

He gave an inferior performance with concrete material but showed adequate speed on the third trial of a test at his age level. He showed adequate muscular co-ordination in his drawings of designs reproduced from memory. He talked more freely at this examination than previously. He admitted not doing his work. He said, "I don't like to write much because my hand gets tired when I feel tired because I haven't had enough sleep." He said he did not get into much trouble with other children, that he could not fight and that "some of the kids did not seem to like" him and beat him up. He got along better in his present neighborhood and liked his present school better because "not so many kids bothered" him.

A year after this examination he was referred again and was given Form L of the Stanford-Binet Intelligence Test. With an M.A. of 12-6 and a C.A. of 13-5, he obtained an I.Q. of 94. Year IX was his basal age and the Superior Adult one was his upper limit. He was slow in giving responses and never clarified his statements, although asked to do so. He gave the impression that he was putting forth extreme effort. He was constantly moving about and sighing.

The patient shows a mild degree of fluctuation in his I.Q., which may be due to differences in the administration of the tests, for they were given by different examiners. His school progress has been uniformly very poor and his attitudes and behavior have been consistently pathological. These results cannot be explained by the psychological or physical examinations. Undoubtedly he has serious intrapsychic problems which may be severe enough to interfere with the associational capacities of the central nervous system. This would produce irregularities in the results of the tests of his intelligence. The diagnosis is that he is a pre-psychotic child, and it is probable that in time he will develop either a frank psychosis or a decreased intellectual capacity.

THE PATHOLOGY OF INTELLECTUAL RETARDATION

The organic pathology of intellectual retardation coincides with the etiological factor. If the intellectual retardation is the result of defective germ plasm, the result is a maldevelopment of the brain; if due to cerebral insults, the pathology is that of the insult. There is no medical treatment that will improve such conditions. If the retardation is due to hypodevelopment of the thyroid, the condition will improve under thyroid administration, if the treatment is begun when the child is very young.

THE PSYCHOPATHOLOGY OF INTELLECTUAL
RETARDATION

The organic pathology due to any of the seven causes mentioned earlier (see pp. 183-184) produces certain specific psychic disturbances in addition to the defect in intelligence. Children with intellectual retardation show poor judgment and poor conception of the relation between cause and effect, i.e., a deficient ability to test reality. Their ability to recognize the future consequences of a present action is usually defective. They are easily led. These symptoms are the results of defective ego formation due to the impaired cortical activity. Freeman and Watts⁸ have shown that prefrontal lobectomy impairs the ability to recognize the future consequences of a present action.

Besides these ego defects, the child suffering from intellectual retardation shows a lack of ability to control his instinctual drives, an inadequate conception of his own rights and those of others, and often a deficient moral judgment. There is an inadequate development of the superego, for two reasons. (1) The superego develops as part of the ego, and since the ego development is defective, the superego development will be also. (2) The superego is formed by the child-parent relationship, and in the case of the intellectually retarded child, the whole parent-child relationship is different from that of the child whose intelligence is average or better. This is true even when the parents are successful, happy, and loving.

At birth or while the baby is recovering from a severe illness (if this be the cause of the defect in intelligence), the parents are not aware that the child's intelligence is retarded, so they proceed to try to train him as they would the average child and are interested in watching the rate of his development. Now habit training in an intellectually retarded child takes a longer time and requires more patient instruction, and its results are not so certain as in a child with average intelligence, for the ability to establish control over and to relinquish infantile forms of pleasure gratification is impaired. The slow responses to habit training and the slow appearance of motor functions—sitting up, crawling, walking, and speaking—are the first indications that the child is not average. At first the parents feel puzzled and make efforts to compel him to try

⁸ W. Freeman and J. W. Watts: "Interpretation of Functions of Frontal Lobe Based upon Observations in 48 Cases of Prefrontal Lobotomy," *Yale J. Biol. & Med.*, 11:527-539, May, 1939.

harder. When their efforts are not rewarded, they begin to realize that there is something wrong^a with the child and try more and more desperately to force him to prove that this is not so. The child responds to the efforts to the best of his ability. He fails, and it seems to him he is constantly failing to please his parents. He begins to feel that he is worthless and that his parents do not like him. When at last the parents have to admit to themselves that the child is backward, their pride is hurt and their attitude toward him ceases to be a happy, loving one. In spite of their sympathy and pity, their feelings toward him contain elements of resentment, irritation, and hopeless apprehension. In short, the ambivalence of their feelings is greatly increased. They may try to repress their hostile feelings by overprotecting and coddling the child, or they may repress their hostility and yet be aware that they are ashamed of the child, or they may be openly irritated at him. Proof of the presence of this high degree of hostility is readily found. Often they feel very guilty—as if they were the cause of the retardation. This feeling of guilt is the conscious representation of a feeling of unconscious hostility—a hostility directed at fate but usually turned on the object of their discomfort—the child. Many parents express a great reluctance to placing such a child in a special day or boarding school lest he be treated brutally, knowing consciously that such treatment seldom if ever occurs in a good school. Hence their reluctance is not based on facts but is an expression of their shame in their child. This shame engenders hostility, of which they are unconscious and which they project onto the teachers in the school. The shame is also indicated by their reluctance to accept the diagnosis of intellectual retardation. Often they take the child from psychiatrist to psychiatrist, frequently at a financial cost they can ill afford, not so much in the hope that the child can be treated or improved as to change the diagnosis.

In any case the child senses the parents' highly ambivalent feelings and feels rejected and therefore insecure. Since adequate superego development cannot occur under these circumstances in any child, it cannot be expected to occur in an intellectually retarded one.

It is interesting to note that when such a retarded child is trained in a particular routine, he becomes well trained; i.e., he clings to the routine very strongly and it is difficult to get him to alter any part of it. That this clinging to routine is a sign of a feeling of personal insecurity has been noted by Benedek⁹ and is the result of inadequate ego and

⁹ Therese Benedek: "The Adaptation to Reality in Early Infancy," *Psychoanalytic Quarterly*, 7:200, 1938.

superego development. Physicians and educators tend to forget the important role that defects in the personality structure play in the case of the intellectually retarded child. Clark ¹⁰ was one of the first to call attention to this fact, and I ¹¹ have written further concerning them in another place.

Not only is the child subjected to adverse attitudes in his relationship with his parents, but he soon becomes subjected to critical attitudes on the part of siblings, other children, and adults who are not members of his family. These antagonistic attitudes arouse his resentment, which he may try to express in open hostile acts. However, he is usually somewhat incapable of competing thus and fails again, to the detriment of his already very weak self-confidence. Often the incapability of competing and the increased resentment may cause him to become a behavior problem in the home, in the school, or in the community. He is then, of course, subjected to more counterhostility, and a vicious circle is formed. If he does not act by mobilizing his aggression or if he finds such mobilization gives him too much pain, he will tend to flee from situations in which he is criticized. If at home he will avoid his siblings; if in school, he will truant; if in the community, he will avoid children of his own age and play either with younger ones or by himself. In school, where he has to stay, perhaps because he is afraid of truanting, he does so in body but truants in mind: he sits and daydreams, paying no attention to the teacher or to his work—probably the least desirable solution.

Serious difficulties may eventually arise. If the child truant, he may fall in with a delinquent child or gang that accepts him because of his usefulness due to his lack of judgment regarding the consequences of their planned depredations. So much of delinquency due to intellectual retardation is the result of such a situation. The individual is teased or annoyed until his control, never very strong, breaks down and he commits a crime of violence—assault, murder, robbery, vandalism, or arson—in retaliation. He finds it difficult to hold a job and drifts into a life of petty theft, vagrancy, and begging. He is led into delinquency by someone who is apparently good to him and whom he repays by obedience—often being apprehended while his more intelligent friend escapes.

Let it be repeated: if a child of average or better than average intel-

¹⁰ L. Pierce Clark: *The Nature and Treatment of Amentia*, William Wood & Co., Baltimore, 1933.

¹¹ Gerald H. J. Pearson: "The Psychopathology of Mental Defect," *The Nervous Child*, 2:9, 1942.

lectual endowment were subjected to similar influences, he would be in danger of quickly developing serious problem reactions.

Now if all these difficulties and reactions occur in the family where the child is the parents' own child, how much more difficult is the situation where the child, as in Case 37, is an adopted one. I have seen a number of such cases. The couple adopt a baby under six months of age and several years later find that he is intellectually retarded. It is not uncommon for a physician tending an unmarried mother to arrange for adoption of the child by some friend or patient of his. Usually he is conscientious, checking the family history as closely as possible, examining the baby carefully to be certain there are no physical defects, and doing a Wassermann test on mother and child. Too often, however, he does not think to have the infant's intelligence examined by a psychologist competent to test young babies. I know that these tests for very young children are not too accurate and give only an approximation of the intellectual status, but they—particularly those of Gesell—are becoming more and more helpful and certainly can determine gross differences in intellectual levels. Such tests should always be done on a baby before he is adopted.

TREATMENT

The therapy for children who are intellectually retarded falls into several categories. Careful study of the child may reveal an organic condition responsible for the retardation that can be corrected by treatment. Except for cretinism, however, and a few other conditions which may be improved through endocrine medication,¹² there is little help that medical or surgical skill can give. Of course, the usual prophylactic measures—adequate care during pregnancy, the prevention of birth injuries and of exposure to infectious diseases, proper human contact, and sufficient appropriate vitamin intake—are of prime importance.

The child should receive all possible adequate training in skills. This is of the greatest importance. If the child can be trained to protect himself from ordinary physical danger, to earn a livelihood, and to adapt himself to social life, he will be a happier and more useful citizen and will not become a financial burden either to his parents or to the state. The child can either live at home and attend a special school or be

¹² In my experience, with careful examination by a competent endocrinologist, the vast majority of cases of intellectual retardation, exclusive of cretinism, show that there is no determinable disorder of the endocrine glands and that therefore the possibility of improvement from endocrine therapy is almost nil.

entered in a special boarding school for intellectually retarded children. If the retardation is great—i.e., an I.Q. of 80 or lower—the latter is, in my opinion, the better plan. Children whose I.Q. is less than 60 almost always require such placement, and in many instances they have to remain under such custody the remainder of their lives because they are incapable of earning a livelihood and often are incapable of protecting themselves from common physical dangers. The group whose I.Q. ranges from 60 to 80 or over is the one to whom most can be offered. The intensive educational experiences that are provided, not only along vocational lines but also in routines and in social poise and grace, in a special boarding school under the supervision of well-trained and carefully selected professional people usually contribute more to their development than could be accomplished at home, except under exceptional arrangements. Of course, the separation of the child from his family is a traumatic experience, but its usual disadvantages are outweighed in this case by the advantages of the skills they acquire in the school. There the child may make attachments to father and mother substitutes who become for him more important than his own parents and remain so. This means that the parents have to give up the child to some extent, but they should be willing to accept the situation for the child's own good.

There is no question in my mind that the training in skills and in social adjustment is done much more effectively in such a special school than can be done at home, regardless of the parents' intentions. We have already discussed the somewhat involved attitudes of the parents of retarded children. A mother who feels too much pity for such a child will tend to help him too much with his daily routines—in fact, do them for him—when what he needs is intensive training in the skills to do things for himself. A mother who is ashamed of her child will try to force him to learn quickly, and if he does not respond, she will become irritated and make him feel rejected and unloved, which reactions will invalidate the learning process. Such emotional reactions are not as likely to occur in a person whose professional interest lies in the education of the child. Too, in the boarding school, the educational experience is continuous round the clock, whereas at home the daily routines, happiness, and interest of the other members of the family have also to be considered. In the school, the child is placed with other children whose I.Q.'s are relatively equivalent to his. Therefore, he is not subjected to the experience of being looked down on, taunted, criticized, teased, or coddled. He is actually able to attain a feeling of

success in his competition with the other children—a success he could never attain with the unretarded children in his community life. All in all, the good special boarding school is the best place for the intellectually retarded child.

There are, of course, disadvantages. I have mentioned one already—the trauma of the separation from the parents. Too, good schools are very expensive, and the question may arise whether so much money should be spent on the intellectually retarded member of a family of small means that has also to provide adequate education, recreation, etc., for other children in the family. Schools whose rates are not so high usually have a long waiting list, and it may be months or even years before the child can be admitted. In my opinion, an intellectually retarded child should start his school training as early as possible, but only a few of the more expensive schools admit children under the age of seven. As to the fear often expressed by parents lest the child suffer ill treatment, we learned earlier that it is usually an indication of unconscious resentment and unjustified. To be sure, cases of ill treatment are not unknown, but their incidence is extremely low and in all accredited schools a teacher guilty of such treatment would be immediately discharged.

If the child is kept at home, the parents should be carefully and frequently instructed by a competent person, perhaps every two months. A competent person for this purpose would be an educator or preferably the psychologist who has tested the child's intelligence. The child will also have to attend a special class in the public school, where, unfortunately, he will be exposed to the taunting of the other children in the neighborhood, who will not hesitate to inform him that he is a dummy and goes to a dumb class. Special classes have competent teachers and are well conducted, but they are inferior to the boarding school in that the educative influence extends to only about twenty-five hours a week, which is only a small part of the child's waking life.

At present researches are being conducted on the use of glutamic acid as a means of improving the intellectual capacity, but it is too early to know whether the results will be favorable. However, in all cases it should be tried, though the parents should be made aware that it is only an experiment and that no hope of cure or improvement should be based on it.

From the foregoing it will be seen that the problem of the intellectually retarded child is that of adjusting to the educational and social requirements of the community, which are easily met by the average child. Therefore all treatment efforts must be directed toward arrang-

ing an environment which will be most profitable for the child and through which he can attain as great ego proficiency as possible.

PROGNOSIS

The prognosis for improvement of intellectual retardation is poor. The prognosis for social adjustment depends on the level of the child's intelligence. If it is very low, the prognosis is poor and the patient may have to be institutionalized for life. If the level is higher and due attention is paid to the educational procedures we have been discussing, the prognosis is better, although the individual may require a certain amount of supervision for the rest of his life.

THE SEXUAL PERVERSIONS

CASE 42. A boy of nine is referred because of his sexual behavior. He has become a neighborhood problem. Two years ago his mother saw him in the alley with his shirt off, pants down, and genitals exposed, with three little girls running around and screaming with laughter. She brought him in and scolded him. Once he gave a little girl two caramels to take down her pants, and on another occasion he tried to persuade another little girl to do the same thing in a churchyard. Last summer he had a friend in his room whom he kissed several times. Recently he told his mother that he wanted to kiss a certain boy and also that he had started a game with his friends in which they took their trousers down and touched their buttocks together. One of the boys went home with his trousers on backward and his father forbade him to play with the patient. The patient pestered another boy to wrestle

with him until the boy had to comply. Recently the mother saw her son with his head on the boy's chest and his arms around him. Later he was seen holding the friend's legs, not letting him go until the friend finally hit him with a book, whereupon the patient bit him in the leg. As a result of his behavior the neighborhood parents have forbidden their children to play with him, and he has also been ostracized by most of the neighborhood boys of his own age. He told his mother that a friend who was constantly after him to go out with him after dark had bragged he had had intercourse with a girl, and that whenever the friend passed a girl he would say, "Boy, would I like to put my penis in her!" His father thinks the patient acts effeminately. Although he sleeps by himself, in the morning he often slides into bed beside his father.

This sexual behavior was the presenting symptom for which he was referred, but on careful study additional symptoms were found. Both his mother and his teacher noticed that he needed and demanded attention much of the time. At home and in school he masturbated through his pockets. (His father himself had the habit of fumbling with his genitals in public.) When he was about six years old he had a few headaches. Recently they had become more frequent, particularly since the beginning of this school term. Three were very severe and were accompanied by vomiting. A week before, he had a terrible headache which caused him to scream and yell, and he and his parents thought they came from eating chocolate ice cream and candy. The patient himself stated that his headaches were the reason for his referral. He had suffered from enuresis and would continue to do so if his mother did not get him up about eleven o'clock each night to urinate. His enuresis did not trouble his mother much, because his father had wet the bed until he was twelve years old. He liked to play with fire and was careless when he did so. He had stolen small amounts of money, and, when confronted with any of his misdemeanors, he would lie. He also told fantastic stories. Recently he had had many fears, the following being an example: He had a bad headache one day and stayed home from school in the afternoon. He claimed he vomited five times but later admitted this was not true. While in the house he locked all the doors and got out the butcher knife for self-protection because he heard voices in the house.

Toward other children, particularly boys, he showed a passive submissive attitude. He played a great deal with a much stronger boy of his age who had a vicious temper: on several occasions he had treated the patient cruelly, choking him until he was blue in the face; recently

he had held the patient down in the middle of the street, waving a knife blade in front of him. After these episodes the patient picked on a smaller boy and started to do the same thing to him. Recently he had stopped playing with other children and seemed very unhappy.

His school report was poor. He was satisfactory in reading, oral English, and writing but unsatisfactory in arithmetic and spelling. He liked his teacher but did not like school; some of the "headaches" were pretended ones in order not to attend school.

He liked to play with trains and guns, but his father discouraged this type of play. He would not let him belong to the Scouts. The father blamed his difficulties on other people. The patient reacted violently to disappointments, of which he had had a number recently. He was elected president of the student council for a month but lost the position because he did not finish his schoolwork. He treated his dog badly, expecting her to adhere to human standards and frequently beating her because she did something wrong. When he was angry he would say he was going to give her away. One day after he had hit the dog, his mother told him that if he disliked her so much he should sell her to someone who would like her, whereupon he responded with, "You damn son-of-a-bitch, I hate you. I wish you were dead. You wanted me to say that, didn't you . . . you feel bad about it, don't you?" His mother said, "Certainly I feel bad, because I love you and Daddy very much, and if somebody tells you they hate you, wouldn't that make you feel badly?" Then he was sorry.

He was very fond of his father, always eager to see him and frequently wondering whether he would be home before he went to bed. He was very impatient with his mother and often attacked her, hitting her in the stomach. On one occasion he became enraged at her during a movie because she wanted to see part of the picture again. He stormed at her, bit her on the shoulder, and stalked out of the theater.

History. His father flunked the last year of high school because he did not study and went out too much. He worked five years on a newspaper and about eleven years as chief editor of a historical research project. While writing, he always had many different ideas and took four times longer than anyone else. What he wrote was only "half as good or no good at all." He gave up writing because he felt too tired and did not seem to have any energy, and took a job with a government agency in order to have a steady income. He has not tried writing since. He admitted that fear of failure played a large part in his changes of occupation.

His wife said that he married because he wanted to get away from his mother. As a child, he had chorea and much gastrointestinal trouble. Recently he vomited blood, and the X-rays showed that the lining of the stomach was swollen and inflamed. He also bit his finger nails.

During his wife's pregnancy and after the baby was born, he began to stay away from home at night. He drank a lot, spending most of his money on liquor. He stated that he was sorry he had a child and did not want any more. He refused to have intercourse with his wife, or if he agreed he demanded anal intercourse as a contraceptive measure. His wife objected to the practice. There was much quarreling. When she tried to discuss anything with him, he would walk away. Often he flew into a rage, at which times he would strike her. The patient became very excited on these occasions. Once when the boy punched his mother she grabbed his shirt, and his father tore all her clothes off her. The boy screamed for a long time, crying, "I hate him, I hate him, I hate him, I hate him." Another time when the father got into a rage and went toward the mother the boy cried, "Don't touch her, don't touch her." The father chased him upstairs. She went up to try to calm him down, but the father followed her, punched the light out and knocked the glass all over the floor.

The father complained of fatigue and pain in the legs; he walked in his sleep and had terrible nightmares followed by great confusion. One night the father dreamed that he was in his old home in his room and that his mother (the patient's grandmother) was downstairs and a man was attacking her. He did not know the outcome because he woke up and tore down the stairs, with a glazed look in his eyes.

He seemed to have sexual feelings toward the patient. Often the boy would get into bed with his father. The latter, who slept clad only in pajama tops, would hug and kiss him and hold him close. The boy would stay about half an hour. If the mother criticized the practice, the father became very irritable, telling her he was only being affectionate to his son.

The mother had always been frigid in her sexual relations but concealed the fact from her husband because of fear that the truth would make him feel inadequate. However, she did not wish to separate from him because she loved him in spite of everything and because the patient was so fond of his father. Also, she lied to him about money. She had been very indulgent to the patient. She had washed him until quite recently.

Her Rorschach test gave the following results. She appeared to be a

very insecure person. She was responsive to her environment, but showed tendencies toward introspection. She was emotionally immature and dependent. She was impulsive and occasionally aggressive because of her insecurity and anxiety. She had good practical common sense but disliked abstract thinking. She had capacity for good but rather superficial social relationships. She found it difficult to take things seriously. She had good control. She was neurotic, probably of a hysterical type, and her disturbance was rather deep. She seemed to have high average intelligence, but her insecurity and inability to form independent judgments interfered with efficient functioning. She had the ability to form rapport. This Rorschach report agreed accurately with the psychiatric observations.

History. The patient had a hemolytic streptococcal infection at the age of two from which he nearly died, and although he was so ill, his father would not go to the hospital to see him. He had no other illnesses.

Examinations. His physical examination was negative, and his electroencephalogram was normal.

His Rorschach test gave the following results. The subject was neurotic, suffering from great anxiety. He was stimulated primarily from within and had a strong tendency to live in fantasy and evade reality. He had great fear of emotion and seemed to be endeavoring to escape his strong homosexual desires. His control was too rigid, owing to his fear of expressing his feelings. He had little initiative and did not express his aggressions outwardly. His anxieties prevented him from using his fairly good mentality to do well in school. He had capacity for relating to people. The prognosis for psychotherapy was good.

The report of the Thematic Apperception Test was as follows. The patient's stories were filled with instances of coercion and restraint. Someone tried to force the hero to do something or prevented him from doing it. He was the aggressor and the criminal and was duly punished. Legitimate authority was represented by the mother and the policeman. People were attacked or killed without cause. The hero criticized and reproved himself for wrongdoing. The boy in the story was going to be a good boy, would grow up to be good, and would get a good job. He revealed the things he had wanted or been tempted to do. A girl truanted, and he thought her father would make her go back to school. He stated he would not like to truant. A boy played with matches and his father stopped him. He stated he did not like to play with fire. (His mother had said this was one of his principal interests.) The characters in the pictures were uncertain and indecisive, and their

impulses, needs, and desires conflicted. From his stories about the mother figure in the pictures, the psychologist inferred that he seemed to have conflicting feelings about his mother. She punished him. He found her dead. He ran away from her and came back when he grew up to give her money but was ashamed to tell her who he was. His stories about the father figure were more directly hostile. The older man was killed and the woman married again and lived happily ever after. The patient identified himself with an older boy or someone who was not a parent figure—sometimes with another boy about his own age. His relation of the incidents in the story was not clear. The older boy would tell the younger to do something and the latter would be surprised at the request. The boys played tricks on people and sneaked up on them from behind. An older person put out the light and saw the younger boy running around. (These are probably the patient's way of expressing indirectly his homosexuality and his sex play.)

I am including here the results of his Sentence Completion Test.¹ In this test the subject was given a page on which were printed the words shown in small letters. He was asked to complete the sentence. His completions are printed in capitals.

Sentence Completion Test:

If I were bigger IT WOULD BE NICE
 I would like TO BE BIG
 If I could only SWIM
 I hate MICE
 Oh, how I wish I HAD A GOOSE
 I used to love to JUMP IN BOXES
 What makes me sad IS THAT I HAVEN'T GOT A TYPEWRITER
 Someday I'LL PLAY A VIOLIN
 I miss so much MY LITTLE TOY MICKEY MOUSE
 I want to go to THE BEACH
 When I'm alone I'M LONELY
 I want to see A WALNUT
 Once I FELL OFF THE DIVING BOARD.
 I'd like to be A BIRD
 If I were brighter I WOULD KNOW MORE
 I love MY MOTHER
 Girls ARE GOOFY

¹ I do not believe that either this or the Thematic Apperception Test is very useful. Their results give some indications of the subject's fantasies but the material can be elicited as readily in the ordinary interviews, where it can be utilized in therapy.

My friends think I AM VERY NICE
 I like best of all TO SWIM
 I want to know HOW TO TYPE REAL FAST
 When I get older I'm GOING TO GET A JOB
 My mother and father ARE NICE
 I feel like A FEATHER
 I get mad because A GIRL I KNOW PESTS ME
 Sometimes I think I'LL BE A BETTER BOY
 I dream of BEARS
 My mother doesn't SNORE
 When I wake up at night I'M HUNGRY
 God is VERY, VERY NICE
 Boys ARE NICE PLAYMATES
 I am afraid of LIONS
 What makes me mad WHEN I FALL IN THE WATER WHEN I'M
 DRESSED
 Other boys and girls LIKE TO EAT
 My father isn't A BAD MAN
 I am jealous of (I AM NOT JEALOUS)
 I look like MY FATHER
 I think most about GAMES
 I am proud of MY FATHER AND MY MOTHER
 Other people think I'm VERY NICE
 I am sorry WHEN I'M BAD
 I try to BE A GOOD BOY
 I get fun out of GAMES
 I feel unhappy sometimes because THERE'S NOBODY TO PLAY WITH
 When I get home, I'm going to PLAY AS USUAL
 When someone in my family is sick I'M UNHAPPY
 If another person hit me, I'd HIT THEM BACK
 When people come to visit us at home I'M VERY POLITE
 At mealtime I'M HUNGRY
 I am scared to PLAY AROUND A CLIFF
 If I saw a little puppy whimpering in the cold, I'D BRING HIM HOME
 I like to be KIND
 When I play games, I'M FAIR
 If I don't get what I want at home I DON'T GET MAD
 When I hurt somewhere I WISH I WAS HOME

Psychopathology. I am presenting the material from the psychiatric interviews in two sections. The material from the first three interviews will be given in detail, and then I will summarize the data elicited during the course of treatment.

First interview: The patient was a medium-sized boy who appeared to be well developed, although rather slight for his age. He was quiet, polite, and docile. He did not know why he was seeing a psychiatrist and said that he had no difficulties. I asked him if he wet the bed and how he got along with other children. He replied that he wet the bed once in a while and did not get along with his companions. He picked up the modeling clay and made a little man which he changed to a rabbit. During this time he talked to himself. He made the rabbit hop around the box. He said the little man was himself. He wanted to be a man, make money, and give it to his mother if she were still alive. He said rabbits were timid and shy and did not make friends easily. He then made a baby rabbit. When he left, he waved his hand to me as a girl would do.

Second interview: We played a game of checkers. He played poorly, lost, and said, "Phooey," but stated he did not feel angry. During the game he made motions with his lips and put his fingers to his mouth. He said he had no brothers or sisters but did not mind. He would like to have one because he had no one to play with when he could not go outside.

Third interview: He had difficulty in selecting a game with which to play. He hummed and talked to himself. He bit his lower lip and put his finger to his mouth and chin like a shy little girl. He walked like a girl. He wanted a rifle, saying, "I wonder where I can get one." He seemed uninterested in talking. He said he had no girl but did have some boy friends. He went to a birthday party where they played hide-and-seek and puss-in-the-corner. His father was a clerk. He did not listen to Dick Tracy, Jack Armstrong, Captain Midnight, etc., but did listen to Charlie Chan and Ellery Queen. He did not write or paint and had had no music lessons. He would like to play an accordion.

These three initial interviews showed a boy who did not wish to reveal much about himself. In retrospect, they indicated his most important unconscious conflicts: his fixation on his mother and his castration dread (desire to possess a rifle). He also showed that he had the ability to dramatize, the ability proving extremely valuable in treatment.

He dramatized a series of important intrapsychic conflicts. He recognized that he felt unhappy in his home life, saying home was a gloomy place, dreary and uninteresting. He recognized, too, that he had a conflict over his thoughts. He said he could not mention his headaches often because they were produced by thoughts that were not nice.

One of his most important conflicts centered in his hatred, fear, and love for his father and were dramatized in the following play: It was fun to be a little boy. It must be fun to be a daddy. He wanted to grow up and have a boy child. It would be fun to teach a little boy like his daddy taught him. He was not jealous of his daddy. He modeled a gorilla that he called a good gorilla. (The gorilla was a representation of the father.) It was good even when it attacked the boy. He shot arrows at it and put pants on it to make it civilized. The boy was pushed off a cliff and suffered a broken leg. Patient at this point said he was damn glad he did not have a broken leg. The gorilla played doctor and fixed the boy's leg and warned him to behave. The gorilla came again and the boy jumped at him. A war was on. The boy threw rocks at the gorilla.

The play dramatized the idea that he must love his father, that if he became antagonistic toward him, he would suffer an injury—a broken leg, symbolic of castration. *Psychiatrist*: "Are you afraid of your father?" "No." "Why do you wish you could beat your father?" "Then I would be big and strong."

The interpretation and his reply corroborated the fact that unconsciously he had strong feelings of antagonism toward his father and allowed him to dramatize them even to the point of wishing to kill him. He put the gorilla on the floor and pounded it with rocks. He took it to the doctor. He said it would be good in the future. Actually the gorilla was more angry because one of its arms had been amputated. It sneaked up on the boy, but he pushed it off a cliff and killed it.

The psychiatrist intimated that the play-boy was unhappy. Patient stated emphatically that he—the patient—was not unhappy, neither was the boy. This question aroused the boy's feelings of guilt about his hostility, for in his play the boy went to the doctor and got an artificial arm for the gorilla. The gorilla was brought back to life. However, the hostility was stronger than the guilt, for the play continued with the boy throwing rocks at the gorilla and killing it again.

After this the dramatizations of his hostile fantasies about his father and the reasons for them became more specific. He played that a snake jumped at the boy. The boy pushed it back because it was only a baby. Here he was saying that if he could push his penis away or desire it to remain in an infantile state, he would not feel hostile toward his father, indicating, too, that one of his masturbation fantasies was concerned with destroying his penis because it was his possession of it that produced his feeling of hostility toward the father. These hostile feel-

ings were associated with envy and jealousy of the size of the father's penis, as the next series of dramatizations show.

A big snake (a representation of the father's penis) came along and was killed. At the same time the little snake (a representation of his own penis) was killed. The little snake was repaired by the doctor and the boy, and lived happily. He made a large bear (another representation of his father). A snake wrapped itself around the bear's leg. He made a number of snakes and set them on the edge of the box. The bear and snakes fought. All the snakes were killed except the king snake and a small one. The bear left but returned. The king snake and the bear fought. More snakes were made, but all were killed. He made a very big snake which killed the bear, but an avalanche of rocks killed him. The snake thought the bear had been killed, but he was only half killed. He started to make a big fat male bear but changed it to a gorilla. He made snakes, including a big king snake and a baby snake. All the snakes attacked the gorilla. The big snake wrapped itself around the gorilla's neck. The gorilla fell down. All the snakes were in peril, and one was killed. He stated that the king snake and the prince were hurt. The gorilla was hurt, and the king snake was killed. A big battle began and all the snakes attacked the gorilla, but the latter killed all of them. A rock killed the prince. The baby snake grew up and killed the gorilla. He made more snakes. He said that though the gorilla had been killed, he had a baby that grew up. Then he suddenly remembered that the gorilla was a male, so he quickly had the gorilla married. The pair had a baby gorilla, who now fought. The fight had started two years before. The snakes wanted to have fun and bit the gorilla, and the gorilla got mad. He made a bees' nest. The bear got near the nest and the bees stung him.

Then he proceeded to dramatize his desire that the doctor help him in his conflict with his father. The bear got hurt, broke his leg, and came to a squirrel which was a doctor. While making the squirrel, the patient said to the psychiatrist, "This is just like you. You're a doctor and you're no squirrel." The bear went to the squirrel-doctor, who sent the bear to a drugstore to get medicine. Besides being a doctor, the squirrel was also a friend of the bear, and the bear went to him and said, "Hiya. You don't fight with me." The squirrel said, "O.K., but we would like an adventure." There was a bee on a lookout post who spied the bear, but the squirrel sneaked up on the tree and knocked over the nest. One bee got loose and stung the squirrel on the tail. The squirrel fell but was not killed. The bear killed a number of the bees and went to the squir-

rel's help. The boy made a very big male squirrel and more bees. The bear fell down, and the big squirrel was knocked out. The bees attacked the bear, and the squirrel came to his rescue. He stated that the big squirrel was an enemy. When the big squirrel woke up, the little squirrel killed him and the bear and small squirrel lived happily ever after.

Through this dramatization the boy was able to transfer his attitude toward his father to the psychiatrist. The psychiatrist and he played checkers. The former won one and drew one. After the games, the psychiatrist told the patient he was afraid to win. He replied that he could play better but that the psychiatrist was bigger than he and so he was afraid of a fist fight if he won.

When the transference occurred, his sense of guilt about his hostility again appeared. At the same time, he showed a regression from phallic hostility to anal aggression. He made clay models of airplanes. He made two squirrels (the doctor and himself). Both had anuses. He said that one was going to defecate on the other, but he closed the second squirrel's anus, saying it was not fair for the second one to defecate on the first.

His guilt forced him to repress his anal aggression against the psychiatrist, dramatizing that the repression was not in itself a powerful enough defense. In order to maintain the repression, he had to change his attitude from an active aggressive sadistic one to a passive, receptive, and masochistic one. Squirrel No. 1 was in a plane and dropped soft, mushy feces right in the face of No. 2. The plane crashed and squirrel No. 1 broke a leg. He said, "You get fixed up. I am the guy in the airplane. I like you because you're my doctor and you are a nice fellow and I'll let you come in the plane with me." "If you were my father, I would like you. I ought to because you're my old man—that is, you would be."

This passive receptive masochistic attitude was a determining factor in his homosexual orientation, for at this point he said, "Shall we crash?" *Psychiatrist*: "It's up to you." *Boy*: "It would be interesting, but we won't get hurt." He threw the plane into the box, and no one was hurt. This was a more sexual representation of his love for the psychiatrist and indicated what he unconsciously had meant when he said earlier, "The doctor-squirrel was a friend to the bear and the bear went to him and said, 'Hiya. You don't fight with me.' The squirrel said 'O.K., but we would like an adventure'" (a sexual one).

He dreaded his homosexual desires because their combined sadism and masochism would result in castration for both parties. He drama-

tized this as follows: He repaired the plane, saying, "You sleep while I repair the plane. The gremlins are bad and made the plane crash again. Your tail comes off again and both of us are hurt. You lost two legs and a tail and I got conked on the head."

At this point he was able to verbalize his hostile feelings for his father and the reasons for them. The psychiatrist asked him why he fought so much with him in his play. He said they were both angry. The psychiatrist said that perhaps it would be better to kill him than his father for then he would still have his father. The patient said it would be better to kill his father. He said he felt jealous of his father, that *he* wanted to be the one who was married to his mother. At the same time, his dramatizations showed he felt more guilt about his hostility toward the psychiatrist than he did about his jealous hatred of his father. He got a gun and hit the psychiatrist on the head twice and then himself. He killed both. The psychiatrist asked why both should be killed, and the patient replied that he was sorry because he killed the psychiatrist. The psychiatrist—as was proper—assured him that he need not feel guilty because of his hostility toward the psychiatrist.

This material illustrates well the fact that he unconsciously hated his father, felt very guilty and frightened by this hatred, feared his father might learn about it, and so adopted a passive-submissive attitude toward him as a defense.

The unconscious conflicts in his feelings toward the father were associated with other unconscious conflicts in his feelings toward the mother. He was greatly concerned by the fact she did not have a penis and wondered how it had occurred and whether it could be remedied. He made a squirrel (the mother). He wanted to know if the psychiatrist wanted a larger house. He made two squirrels (the doctor and himself) and then a rabbit (the mother). The rabbit was looking for the squirrel. The squirrel sneaked up on the rabbit and both fell off the cliff. The rabbit broke its leg and went to the squirrel and the doctor fixed up the broken leg.

He dramatized a contest with his mother. The squirrel sneaked up on the rabbit and pushed him but did not hurt him. Later the squirrel pushed the rabbit off a cliff, but the rabbit climbed up again. The two animals stood side by side, not seeing each other but looking over the cliff. When they saw each other, they started fighting and the rabbit was knocked out. It recovered and knocked the squirrel over the cliff, and then the rabbit was sorry and jumped over the cliff himself. The

squirrel recovered, and the rabbit shoved the house over but the squirrel rebuilt it.

In this play, where he seems to be quarreling with the mother, the quarrel is only an apparent one. It represents two important intrapsychic conflicts. As a defense against his jealous hostility toward his father, he had regressed to the anal-sadistic stage of development. His love for his mother, therefore, was the sadistic love of that stage, and his dramatization of quarreling playfully with her portrayed his marked unconscious sadistic love for her. Part of his sadism was conscious and overt. He tormented flies and snakes. He enjoyed finding, killing, and skinning the latter. One of the little ones he skinned alive. He said the mother snake was larger than the father and inside her were little white things that he thought were eggs. He found unhatched snake eggs which he opened with a hatchet. One day he brought a praying mantis. He made a chain of clay around its body in order to manipulate it, assuming a don't-care attitude. He treated it roughly by throwing it into the air. Another day he brought a grasshopper with its wings torn off and put it in an empty ball of clay. He had a clay man holding it. The psychiatrist mentioned that some people keep snakes as pets. The patient replied, "Pets. I might like to if I could keep from torturing them." He said he liked to torture some things and not others. He could not enjoy torturing dogs, cats, canaries or any birds, a praying mantis, turtles, or squirrels because they were cute, harmless, and defenseless. He liked to torture "snakes, worms, snails, mice, rats, blood-suckers, grasshoppers, wasps, flies, and anything that stings." When his attention was called to the fact that most of these animals resembled snakes except flies, he said that flies were that shape when they were babies. It made him happy to torture them and he did not care whether they had feelings or not. In fact, he hoped they did.

His second conflict concerned his idea that a woman lost her penis during intercourse. The female genitals aroused marked feelings of curiosity, fear, and desire. He feared his sadistic desires to have intercourse with his mother lest he hurt her by injuring her genitals (her penis). Also, he tried to avoid girls. He had no girl friends. There were a number of girls on his street, but they were all crazy. They played with dolls. Although he tried to avoid them, his curiosity as to whether girls have a penis was so great that it drove him to try to inspect them constantly, which resulted in so many real punishments that he became very defensive. After an episode in which he had taken a little girl's pants

down and which he was aware the psychiatrist knew about, he introduced the subject by saying, "I got gypped this week. I was playing with a little boy who took a little girl's pants off and I got blamed. But I didn't do it." He protested that he was not the instigator in this episode, even though he had been the active participant in other similar episodes. He thought the boy who instigated this one was "goofy."

The fixation of interest on the penis, which he dramatized so constantly, was the result of his fear of castration. He inspected girls to find where the penis was hidden. He dared not imagine the existence of a human being without a penis, for such a concept would mean that he too might lose the penis, and this idea filled him with terror. This was another factor that helped to determine his homosexual orientation: he could feel comfortable and happy only in loving a person who possessed a penis.

His fixation on the mother resulted from the father's complete rejection of him when he was a small child, as did also his regression to the anal-sadistic stage. Too, his sadistic desires toward the mother were increased by the father's actions toward her which permitted the patient to express some of his sadism overtly. This overt sadism was partly a defense against his unconscious masochism, which appeared in his relationships with his father and his five male friends. The older boys, even boys his own age, picked on him because they knew he could not fight. He modeled a boy in clay and said he would not like to be a girl—a boy's life was more exciting. He would not want to be a copywriter or a doctor. Perhaps he would like to be a nurse like his mother. He liked excitement but did not want war lest he be killed.

These statements indicate that unconsciously he has regressed from the stage of object love for his mother to the earlier stage of expressing love through identification with her. They express his unconscious wish to be a woman—his mother—and thus gratify his longing for his father to love him. This produced a further homosexual orientation but of a specific type. The final solution of his conflicts was a passive masochistic homosexual one, and it was with this orientation that he was approaching puberty.

Diagnosis. The patient was referred partly because of his sexual behavior and partly because of his headaches. The parents did not attach much importance to the symptom of enuresis, probably considering it a congenital familial weakness that would improve automatically at puberty.

When the boy's problem is investigated carefully, it becomes obvious

that he is a passive homosexual with a strong tendency toward voyeurism. He suffers from a perversion. Since all children at this period show an increased tendency toward a homosexual orientation as well as toward voyeurism, there may be some question as to whether the diagnosis of a perversion should here be made. These activities, however, are usually not so pronounced as in this patient. They are carried on very much in secret and do not go to the lengths that his do. The diagnosis of perversion seems justified.

What is a perversion? All small children obtain sexual pleasure from the use of other organs than the genitals, obtaining, in fact, greater sexual pleasure from these other organs. This stage of development passes as the child solves the Oedipus situation which ends with the primacy of the genitals, the early pregenital pleasures being relegated to the minor role of forepleasure in the sexual act. Also, small children are oriented to both homosexual and heterosexual objects, the homosexual predominating during the latency period. With adolescence, the homosexual orientation is repressed and becomes sublimated into friendship, companionship, etc., in order that the heterosexual orientation may be dominant. The ego accepts the fact that a homosexual orientation exists but demands that its expression take a sublimated pathway. If, however, the ego rejects the homosexual orientation completely, it finds expression in the form of a neurosis—perhaps with the symptom of being afraid of persons of the same sex. If the ego approves of the homosexual orientation, it appears as an overt perversion.

If the ego accepts the pleasure derived from looking and utilizes it directly as a form of sex play and demands its further use in sublimated ways, no neurosis or perversion results. If the ego rejects this pleasure, the desire to look breaks through as a neurotic symptom—perhaps as hysterical blindness. If the ego approves completely, the desire to look dominates the sexual life and becomes a perversion.

THE PSYCHOPATHOLOGY OF THE HOMOSEXUAL PERVERSION

The basic discussion of homosexuality and other perversions is found in Freud.² All human beings are bisexual anatomically, physiologically, and psychologically but the person with a definite homosexual orienta-

² Sigmund Freud: *Three Contributions to the Theory of Sex*, Nervous and Mental Disease Publishing Co., New York and Washington, 1930. (This book should be read starting with the second chapter, with the first chapter read last.)

tion has come by it as the result of disturbances in the sexual impulse during his development. There are degrees of inversion. Some homosexuals are either indifferent to or repelled by the opposite sex. Some are indifferent to the sex of their partners and can have relations with either sex. They can be heterosexual at one time and homosexual at another. This alternation of orientation may take the form of periodic fluctuations. It results from early painful experiences at the hands of some heterosexual object (usually the parent) or from being threatened with severe punishment for approaching the opposite sex. Sometimes the inversion is induced by external circumstances—for example, when a heterosexual object is inaccessible (as in the case of prisoners and of sailors long at sea) or when a person is seduced by an overt homosexual, the intensity of the experience overcoming all scruples.

The person with a homosexual orientation may have various attitudes toward his inversion. He may accept it as a matter of course. He may come to regard it as morbid because it has gotten him into some trouble with the social organizations. Feeling it to be a morbid compulsion, he may strive against it because of the strength of his heterosexuality, or because he finds it difficult to sublimate his strong homosexuality—which has been accentuated by an infantile need for physical care from the parent of the same sex, by a morbid fear of aggressive feelings toward the same parent, or from constitutional reasons. The striving against homosexuality may produce a compulsive heterosexuality. Particularly in children during the latency period or early adolescence, it may cause a desire or an attempt to change their sex. Sometimes the striving against homosexuality results in the homosexuality being projected, in which case the individual develops paranoid ideas and reactions. Of course, attitudes toward homosexuality vary with the culture, with the times, and with particular climates and races.

There are two main causes for a homosexual orientation—biological and psychological. As to the first, I doubt that homosexuality can result from a biological basis only. I know that experimental disturbances in the endocrine glands in animals can alter the sexual orientation and secondary sex characteristics. But it is my impression that alterations in the endocrine glands as the result of disease or injury do not produce a real change in the individual's sexual orientation. Wright³ states that "if the testes are removed before puberty, the rest of the reproductive apparatus does not develop; the vesiculæ seminales and prostate are small and atrophic and the secondary sex characters characteristic of

³ Samson Wright: *Applied Physiology*, Oxford University Press, New York, 1940.

puberty do not appear. There is no growth of hair on the face, trunk, or axillae; the pubic hair is of the female type, the outline being concave upwards; the growth of the larynx is arrested. There may be abnormal deposition of fat on the buttocks, hips, pubes, and breasts. The muscles are soft and poorly developed. There is some delay in the union of the epiphyses but no regular tendency to gigantism: some eunuchs are short, others are tall, and on the whole they show the same range of variations as do normal people. Castration after puberty produces changes which vary very much in degree in different subjects. The seminal vesicles and prostate always atrophy. There is little alteration in the voice, and the penis remains of normal size (it was usually amputated in the case of Eastern eunuchs). In some cases the general bodily changes resemble those described for prepubertal castration; in others they are not very marked. Sexual desire and erection may be absent; but there are many instances in which sexual activity was little impaired, successful coitus (with ejaculation of fluid from prostate or seminal vesicles) being frequently effected for as long as twenty-five years after castration. Rats or guinea pigs may copulate for months after castration, and human eunuchs are often quite promiscuous—ten out of twenty-five studies were found to be suffering from gonorrhea. There is no evidence that castration damages any function except that of the accessory organs of reproduction, nor does it shorten life or produce premature senility. Many castrates have shown the highest intellectual attainment. In some, it is true that a peculiar mental state may result; this is more likely to be due to the psychological trauma produced by the castration than to loss of any internal secretion formed by the testis. If modern psychology is to be believed, the mere subconscious fear of castration may produce serious mental symptoms, although the testes are functioning perfectly normally.

"If the vas (ductus) deferens is ligated, no changes occur in either the somatic or the psychical sexual characteristics.

"If the testis fails to descend into the scrotum, the seminiferous tubules remain infantile in structure and no development of spermatozoa takes place; the interstitial cells are unaffected. If the condition is bilateral, the individual is sterile but the secondary sexual characters develop normally. It has been suggested that the lack of development of the seminiferous tubules in the cryptorchid is due to the higher temperature to which the gland is exposed in the abdomen as compared with the scrotum; if the scrotum is kept artificially warmed, or if the testis is deliberately transferred to the abdomen, spermatogenesis ceases. Ex-

perimental work shows that the internal secretion is still being produced in these testes (although nothing is known about it from the quantitative point of view) even when the epithelium of the seminiferous tubules is completely degenerate." The boy in Case 42 showed no disturbance of the endocrine glands.

There are three psychological situations that can induce a homosexual orientation:

1. Homosexuality can result when a boy is raised entirely by males and so never has an opportunity to experience feelings toward the opposite sex or, conversely, when there is no father or father substitute. It can follow a seduction in a boy's early life by an older homosexual person.

2. Individual boys react differently to the reality of the fact that a woman has no penis. If the awareness follows a long series of castration threats, the boy will be very shocked because of the intense castration fear he develops and become disgusted with women and shun them.

3. During childhood, a boy may suffer severe disappointments at the hands of his mother or mother substitute, and in order to avoid further disappointments enhance his homosexual orientation.

The small boy, in order to cope with his intrapsychic problems, may identify himself with his mother for a number of reasons which are revealed in the type of object chosen by the homosexual. Freud states that a homosexual orientation is caused by an intense but short-lived fixation on the mother as a love object. The boy tries to overcome this fixation by identifying himself with the mother and so taking himself as the sexual object, proceeding on a narcissistic basis: he looks for young men to love as he wished his mother had loved him. Or the boy has experienced severe frustrations at his mother's hands and identifies himself with her in order to avoid further frustration, as if he were saying, "If my mother does not love me and always frustrates me, I will be my mother and then I can control the frustrations I experience." This too results in the person taking as a homosexual object a boy younger than himself and behaving toward him as he would have liked his mother to behave. He identifies himself with his mother and his homosexual object with himself. Sometimes the identification with the mother takes place because the small boy fears her displeasure if he expresses openly his hatred of a younger brother. He represses the hate and acts in an overloving way toward him, the way the mother acts. The homosexuality is, then, an overcompensation for hatred, and here the age of the partner does not matter. If the identification with the mother is associated with

a fixation at the anal-sadistic stage, the homosexuality expresses the wish to enjoy sexual pleasure the way the mother does. Here the partner is usually older and the homosexual person is passive in the relationship. In one type of homosexual orientation only—the active aggressive male homosexual—the homosexuality is caused by the displacement of the excitation produced by a relationship with a female onto a male object. Once this has happened, it may become repetitive.

The sexual aim in the homosexual relation shows no uniformity. It may be the anus, mutual masturbation (this is the most common in men) or the mouth (this is the method preferred by homosexual women). It is a fact that jealousy is more pronounced in homosexual relationships than in heterosexual ones.

The boy in Case 42 is homosexually oriented. He has practiced both homosexuality and voyeurism. He appears to be much fonder of his father than of his mother. Thus he identifies himself with her. He does not wish consciously to be a girl, thus differing from other homosexual boys who openly admit the desire. His enuresis—although it may have a constitutional factor—seems to result from an unconscious fantasy that he is a girl, a condition caused by fear of a relationship with the parent of the opposite sex. His homosexuality is of the passive receptive type. His love object is a narcissistic one. He loves and would like to be loved by the person he wants to be, his father. In order to accomplish this, he is willing unconsciously to give up his masculinity and accede to the desire of the father to make a sissy out of him. The obsequious submissive longing to be loved by the father is the result of his fear of the rejective father. This fear causes him to repress all his jealousy and hostility toward the father and, in order to keep it repressed, to accentuate his passive submissive erotic wishes toward him. If he can be as submissive as possible, if he can deny any love for the mother and any jealousy or hostility toward the father, if he can give up all his masculine strivings, then his father will not only treat him more decently but actually may love him.

In order to maintain this passive submissive erotic attitude, he has to regress to the anal stage of development. The regression does not solve the conflict between his active and passive desires toward the father. The passive submissive erotic attitude toward him does not bring all the love he desires. He experiences disappointment and so has to deal again with the conflict between his hostile aggression to the father and the need for his love. This conflict now occurs at an anal-sadistic level as the conflict between sadism and masochism. Toward animals and

his mother, he is sadistic; toward boys and his father, he is masochistic.

But his problem has not been solved. He has become afraid of his homosexuality because it is passive receptive: if he allows it full expression, he may become a girl and lose his penis. He tends, therefore, to project it, the paranoid tendencies appearing in his insistence that all the doors be locked at night. He fears (unconsciously wishes) that a man will break in and assault him sexually.

THE PSYCHOPATHOLOGY OF THE PERVERSION OF VOYEURISM

The patient also displays a larval form of the perversion of voyeurism. We already know that every child does and thinks things that in an adult would be perversions. That he gets sexual pleasure from the mouth, anus, hands, eyes, ears, nose, and other parts of the body; from touching, looking, smelling, and tasting inanimate objects such as articles of clothing, particularly if they have been worn by a person he loves. Before puberty the child's sexual life has not yet been consolidated under the primacy of the genitals; he has not yet attained the complete development of genital sexuality. After the primacy of the genitals has developed, as we have seen, all of these infantile sources of pleasure are utilized during the forepleasure—i.e., petting—in the relations with the sexual object, although ordinarily the forepleasure is passed rapidly in order to attain the aim of sexuality; i.e., sexual union of the genitals, which is the normal aim of the sexual act. The perversion, on the other hand, is a lingering at the stage of forepleasure to the exclusion of genital union. Its aim is a union of other parts of the body. In the adult, the tendency to linger at the stage of forepleasure is strengthened by all outer and inner determinations that impede or hold at a distance the attainment of the normal sexual aim. In premarital sexual relations there may be fear of pregnancy. Or there may be fear of dangerous results of the sexual act, of castration or of injury to the sexual partner. If the inner determinations are serious intrapsychic conflicts, then the aim to attain genital union is given up completely and the perversions of touching, of voyeurism and exhibitionism, of sadism and masochism result.

Our patient's voyeurism is close to a real perversion, having causes other than lack of physiological ability for genital union. His desire to look at the genitals of little girls is not merely that of ordinary childish sexual curiosity. The analysis of his homosexuality indicates that he

fears castration; thus his voyeurism must also be connected with his fear. He inspects the genitals of little girls to assure himself—like whistling in the dark—that he is not afraid of a person without a penis. Also, he does so with the hope that girls do after all have a penis—that there is no reality in his ideas of castration.

He fears his homosexuality. If he can prove to himself that he is really most interested in girls, he will not have to become aware of his homosexual desires. His interest in girls and their genitals is, therefore, a compulsive denial of his homosexuality, indicated by the fact that he only looks—he does not attempt a genital union. Furthermore, the inspection takes place under such circumstances that he is almost sure of being discovered—and punished. He seems, in other words, to utilize the voyeurism as a way of assuaging his sense of guilt. In the same category falls his boasting to the mother about his behavior—knowing that she will be displeased and angry.

There are three other symptoms to understand. He lies (1) to escape the pain and humiliation of punishment, and in this he does not differ from other human beings. Lying is a problem that is usually caused by the parents' attitude toward the child when he tells the truth: he gets punished. He lies (2) by telling fantastic stories, a form quite common in childhood—in fact, in adult life as well: most people add a little to the stories they tell in order to make them more interesting. His tendency to tell fantastic stories is an attempt to compensate for his feelings of inferiority and inadequacy—which feelings are the result of his castration fears and his homosexuality.

He steals. Stealing is a symptom with many complicated motivations. In our patient it seems to be symbolic, its driving force arising from his desire to steal affection from the mother: he will not be punished by the father for stealing her affection. It arises also in his desire to steal the father's penis, thereby making himself more adequate. He feels that his inadequacy is caused not by his fears but by the small size of his penis. His stealing habits, therefore, have psychological determinants and will not disappear until these determinants have been corrected.

He suffers from headaches. He uses headaches as an excuse to avoid going to school, because he does not like to work and because he fears the close contact with other boys. He and his parents thought they were due to excessive (?) eating of chocolate, a fact partly corroborated by the finding that he was allergic to chocolate. Part of the cause of the headaches, therefore, was organic. But careful study of their occurrence indicated that they often occurred when he had not eaten chocolate

but felt very guilty. They were, therefore, an expression of tension—tension arising from guilt.

It can be seen that the headaches, the stealing, the lying, and the voyeurism are all symptoms and that he will not profit much from symptomatic treatment. His basic problem is his homosexual orientation, which will require treatment directed toward its causes.

Treatment. From the above discussion it can be seen that the boy's behavior is the result of his intrapsychic conflicts, which arose in the past because of his family constellation and are now internalized and part of his personality. He is now unconscious of their presence and is surprised and dismayed when his behavior gets him into trouble. Therapy, therefore, has to be directed first and mainly toward his intrapsychic problems: by psychoanalysis or at least through a psychoanalytically oriented psychotherapy, conducted by a trained child psychoanalyst. It cannot be conducted by a nonanalytically trained psychiatrist or a general practitioner or pediatrician, for their training does not include the skills necessary to explore either the conscious or the unconscious mental life of patients.

Besides the direct intensive treatment of the patient, it will be necessary to consider the problem of the maladjustments of his parents and how they affect him. The removal of their influence—whether by treatment of the parents or by removal of the patient from his home—will not in itself result in his recovery, since, as we have seen, he has internalized his problem. However, treatment will be hampered by their unwholesome attitudes toward him, which result from their own problems. Their problems—those of the father in his evident latent strong homosexuality and lack of ability to take advantage of opportunities that could bring success, and those of the mother in her very inhibited sexuality and determination to have her own way—indicate conflicts that are as deep-seated and unconscious as those of the boy. They too would profit by intensive psychotherapy; i.e., psychoanalysis. If this can be done, the boy could remain at home during his therapy; if not, it would be desirable to remove him from his home. Since problem behavior will continue for some time even while under treatment, there may be difficulty in finding a foster home for him, in which case he can live in an institution while undergoing therapy. However, since there are not many institutions for children where adequate therapy can be conducted, it may be necessary nonetheless to leave him in his home and put up with a longer period of therapy than might be considered ideal.

I present this case here for the purpose of understanding its psychodynamics and not to give detailed suggestions as to therapy. I may say that the patient was treated over a long period of time and that although I am not satisfied with the clinical results of his therapy, those of his Rorschach test show that he has improved greatly. I quote the results obtained about two years after the original test. "The patient has superior intelligence. He seems now to have good control and is fairly well balanced. He tends to be more stimulated from within, although normally he is extremely responsive to external stimuli. This may be either a result of psychiatric treatment, which seems to make people more introverted, or a basic schizoid trend. In either case, it is well controlled at present. There is some residual anxiety related to masturbation or some other guilt, producing fear of castration. He is probably docile and well behaved, but is somewhat insecure and is hesitant in responding to emotional stimuli. He is not aggressive, and his timidity prevents him from attaining his rather ambitious goals. There are many favorable factors. He has good capacity for sublimation and can relate to people in a constructive and socially acceptable way. Some of his fear is unconscious in origin, but it is not overwhelming, and he can carry on in spite of anxiety. He shows capacity for further maturation. He needs successes in real life to give him confidence and stimulate his initiative."

COMPULSIVE MASTURBATION

Children who have a compulsion to masturbate regardless of environment also suffer from a perversion.

CASE 43. A four-year-old girl is referred because she masturbates by rubbing her legs together. She presses her legs together tightly and becomes so covered with perspiration that even her hair becomes wet. During this performance she holds on to a doll, her breast, the side of her crib, or a table. Sometimes while going up the stairs she stops to do it and the family is afraid she may fall. She has never used her hands. When asked why she does it, she says she likes to. Frequently she informs the family when she is about to do it, saying, "I am going to pull." Often she promises to stop, saying, "After next year, when I will be five, I am not going to do it." She has been punished frequently by being put in the corner, spanked, and deprived of things she likes, but without avail. The masturbation started at eight months and has increased year by year. Occasionally she has stopped, but after a short time begins again.

History. Her maternal aunt had made the referral and brought the patient because the mother worked, was too nervous, and had no patience with the child. The aunt was so disturbed by the child's behavior that she burst into tears while describing it. She had already taken her to a doctor, who diagnosed rectal pinworms.

The patient was said to be intelligent. She played with her brother and sister and with other children. She got along better with her sister, ten years old, than with her brother of nine. Although she was cute, she was not too much admired at home.

Her birth occurred at the end of a nine months' pregnancy. Labor lasted only one hour. She was breast-fed for four months and bottle-fed until eleven months. Her appetite was usually good, but in spite of this she cried constantly. She sat up at seven months, walked at nine months, and talked at twelve months. Her toilet training was completed at eighteen months, after which she always waked up several times a night to go to the bathroom, sometimes wetting the bed if lying uncovered. She had no childhood diseases but had head colds about four times a year. She slept in the same bed with her parents until she was eight months old.

The father was eleven years older than the mother. He did not start work until late in the morning and often returned home early in the afternoon. He was reported to spend all his life trying to make the children happy. He was a narrow-minded, nervous man who often lost his temper. The patient's mother sucked her thumb until she was sixteen years old, during which period she had the habit of pinching the skin of her sister's forearm while making peculiar movements with her mouth. She married at twenty-three, and the marriage was unhappy from the beginning. She was not in love with her husband but felt she had to get married because all her girl friends were doing so. Recently the marital unhappiness had increased; for the two previous years the father and mother had not spoken to each other and had slept in separate rooms because the father had slapped the mother's face. He slept with his son and the mother with the two girls. The parents would never separate because it would not be right for the children. The mother worked. The children were being cared for by the aunt and the grandmother. The latter was the first to notice the patient's behavior. The mother was a nervous, irritable, and unhappy woman who seemed to be bothered by everything. She shouted at her children and flew into violent tempers.

The three children fought constantly. The older sister still sucked her

thumb on the way home from school, when by herself, and while thinking. The sister and brother were jealous of the patient.

Examinations. Physical examination revealed no abnormalities. Her electroencephalogram was the usual one for a child of four.

The psychologist reported that the minute she left the aunt, she started to cry. Everything was tried to calm her, but she merely cried harder. She would stop for a few minutes and then start again. She only wanted her aunt and kept rushing to the door to find her. When the psychologist and the patient could not find the aunt, the patient said she wanted to go for a walk. She stopped crying while she walked up and down the hall and showed a great deal of interest in the people there. When she finally returned to the testing room, she cried again. When her aunt came the patient would not leave her, so the aunt was present during the testing.

The patient had a basal age of three years and six months and an upper limit of six years. Her vocabulary was at the four-year level but since she defined words like ball and hat at the five-year level, it really was accelerated beyond her years. She obeyed simple commands at the four-and-a-half-year level. Her memory was quite good. She repeated a sentence correctly at the four-year level. She had an I.Q. of 128, so she had superior intelligence.

I am presenting the material from a number of interviews with the psychiatrist in order to illustrate her psychic problems.

At the beginning of the first interview she would not leave the aunt and hid behind her skirts. The psychiatrist sat on the floor and began to crayon. She finally became interested, joined in, and permitted the aunt to leave. She seemed happy and frequently teased the psychiatrist. She drew pictures and derived a great deal of fun out of having him guess what she was drawing. She laughed loudly when he could not. When he asked what she had drawn, she laughed, saying she did not know. She insisted on seeing what the psychiatrist drew but would not let him see what she drew. She enjoyed strewing the crayons on the floor and laughed heartily when she broke one accidentally. Often she refused to take the particular crayon offered by the psychiatrist. She drew a bizarre figure of a bird with an umbrella in each hand. She said her brother and sister fought her but she fought back. At the end of the interview, the psychiatrist suggested that she put the crayons back in the box. She said, "No, you put them back." She resisted the aunt's attempts to dress her. She wanted to come back again and again to tell the psychiatrist things she had forgotten to mention.

During subsequent interviews, she left the aunt without hesitation. In the third interview she modeled with clay for a short time but then became restless and aggressive. She would run in and out of the room to play hide-and-seek. The psychiatrist continued to model with clay and was pounding a piece flat in his hand. She imitated him by putting a piece of clay on his knee and pounding it as hard as she could, meanwhile watching his face closely. Quite suddenly she hit him over the head. She mentioned she was going to have her tonsils out. She asked the psychiatrist to make a hamburger sandwich out of clay and then pretended to eat it. When he said it was all gone, she would produce it from behind her back, with a scream of delight. At the end of the interview she washed her hands and commanded the psychiatrist to give her soap and towels. She would not let him wash his.

In a later interview she brought her own doll. She noticed a new box of clay and assertively said she wanted it. She opened the box and told the psychiatrist to break the big pieces into smaller ones. She handled the clay for a few minutes but did not make anything. She commanded the psychiatrist to make a hamburger and a lettuce and tomato sandwich out of clay. He suggested she make one, but she said, "No, you make them all." She played the game of pretending to eat the sandwich and laughing when the psychiatrist pretended he thought she had really eaten it. Suddenly she said, "I'm going to get something," and ran out, returning with a toy typewriter, crayons, and drawing paper. As she came back in, she dropped the typewriter. It made a loud noise and she laughed. She emptied the box of crayons on the floor and drew a few circles which she said were faces. She outlined her hand on paper about ten times. Several times she took the particular crayon out of the psychiatrist's hand, occasionally giving him back a different one. Then she began to break the crayons in half and to give half to the psychiatrist. When her time was up, she wanted to stay and commanded him to pick up the crayons and toys.

She was ten minutes late for the ninth interview, but said with enjoyment that she was early. When she was reminded that she had been late a number of times before, she readily recalled that she had been responsible for this because she had been "messing around" and riding her bike all around the house. She said she and the psychiatrist were both going to be bosses. She would be the boss of the Christmas tree and decorations and he would be boss of churches, houses, and girls. Together they made these objects out of clay. He made a father, mother, and baby Christmas tree. Once the father accidentally knocked over the

mother Christmas tree and the patient laughed. Several times she said the baby Christmas tree had to walk in the middle between the father and mother Christmas tree. Once the psychiatrist took the father and baby tree and asked if they could not stand over by themselves. The patient said no, the baby Christmas tree had to be between father and mother. She mentioned that she occasionally struck her aunt but not too often because her aunt might spank her.

She was late for the next interview. She stood by the window, looking at the rain, and asked, laughing heartily, "What are you waiting for—Santa Claus?" She gave the psychiatrist many commands. He asked whether she gave orders to her mother and her aunt. She said no, she would be spanked if she did. He asked her if she was ever bad at home. She said yes and then described her masturbation, which she called "pulling," demonstrating how she twisted her legs and perspired. She thought it was bad but did it anyway because she liked it. Now she was older. She was not going to do it any more. It made her all sweaty and would make her legs twisted so she would not grow tall like other people. She said her father took her to the movies and to the zoo and did more with her than her mother. She liked her daddy, mother, and auntie, but nobody played with her like the psychiatrist. She said she fought with her brother and sister even though they were not mean to her. At the end she refused to go, saying she wanted to stay all night and play with the psychiatrist.

The interviews give a good picture of the child. She is spoiled, self-confident, and defiant and seems to have no feelings of fear or guilt. She boasted that she was pretty and that she was responsible for her lateness. She laughed at her aggressive behavior. She said that if she masturbated her legs would grow twisted, but did so anyway. She did not seem to care about anything or anybody and acted at home and during the interviews in an undisciplined manner. She said she would like to break up her parents' marriage and keep her father away from her mother's bedroom.

THE PSYCHODYNAMICS OF NORMAL MASTURBATION

Before the dynamics of this girl's masturbation are discussed, it is necessary to understand the role played by masturbation in the life of human beings, for only then can the problems in this case be studied intelligently. Masturbation is usually defined as the rubbing or manipulating of the genitals by the hand for the purpose of obtaining pleasurable sensations. More broadly the concept of masturbation includes

any stimulation of any part of the person's own body for the purpose of obtaining pleasurable sensations. All children do some masturbating from birth on. It is universal and fairly frequent during the first year of life. It is universal but less frequent between one and two and a half years of age, and during this period more sensual pleasure is obtained from stimulation of the anus and the surrounding skin areas. It is universal and frequent between two and a half and seven years of age. Between the ages of seven and eleven, it is considerably less frequent and does not occur so universally. During adolescence—i.e., after the age of eleven—it is universal and moderately frequent among boys who are psychically healthy, but is not universal among girls. It ceases usually with the establishment of sexual relations, but often there is a period of varying length between the cessation of the one and the beginning of the other. Many girls who do not masturbate during adolescence do so at the beginning of adult life. Many adults masturbate when they are deprived of a satisfactory sexual life for one reason or another—married couples separated for long periods, persons prohibited from contact with the opposite sex because of confinement in prison, or because of military or naval duties, etc.

Usually boys masturbate by rubbing the penis with the hand or, much less often, by rubbing it between the thighs; girls usually do so by rubbing the clitoris with the fingers or by pressing the thighs closely together. At some period—the time is not accurately known—the little girl discovers her vagina and does some masturbating by introducing her finger or other object such as a hairpin, pencil, piece of wood, etc., into the opening. Often an attempt is made to masturbate by touching the urethral meatus or by attempting to introduce some object into it, the object sometimes getting out of control and slipping back into the bladder.

As the result of fears whose origin I will discuss later, the child is reluctant to touch the genitals directly with the hand. When this happens in a boy, the masturbation is continued by touching the penis only when a piece of cloth is interposed between hand and penis, by handling the penis without actually rubbing it, by rubbing the scrotum and manipulating the testes, by rubbing the penis with the thighs, or by the use of an object that takes the place of the hand and into which the penis can be introduced. Many adolescent boys, or even younger, attempt to suck the penis, and some actually succeed. In a girl it is continued by touching the clitoris or other parts of the vulva instead of rubbing it, by pressing the thighs together and moving the legs, by slid-

ing down banisters, climbing trees, sitting on the heel, which presses against the vulva, by bicycling and other activities that produce stimulation of the genitals. The child is sometimes not even aware that he gets pleasure from the act. If the fear is still greater, the hand may be used to rub other parts of the body. There are a great variety of such acts—head rubbing, playing with the hair, wringing the hands, rubbing the closed eyes, nose picking and nose rubbing, lip rubbing, rubbing between the toes, scratching the arms, legs, or toes, picking at finger or toe nails, pulling at the ears, inserting the little finger in the external auditory canal, etc. The child may be aware that he experiences pleasure, but often he is unaware that it is a form of masturbation or that it is done because he is afraid to masturbate the genitals with the hand. Only in his unconscious does he know.

The rubbing of the skin and mucous membrane surfaces of the genitals—particularly the latter—may produce irritation and often a mild superficial infection as the result of the irritation, a common cause of vaginal or vulvar discharge in little girls and of some forms of balanitis in uncircumcized boys. The irritation and mild infection produce itching and therefore a greater desire to rub the part, which in turn produces more irritation and inflammation, and a vicious circle develops in which the rubbing is done not primarily for sensual gratification but for comfort.

The ordinary medical treatment for balanitis, vulvovaginitis, and pruritus vulvae involves a considerable amount of manual manipulation of the very sensitized genital skin, and the medications used often themselves produce a certain degree of irritation and itching, adding to the vicious circle. The medical advice not to touch the parts is hard for a child to follow if the itching is severe, and the more emphatic the advice, particularly if accompanied by threats of punishment, the more the child cowers under the influence of his unreasonable fears about masturbation.

MASTURBATION FANTASIES

Masturbation is accompanied by fantasies. There seems to be a difference between the way the child masturbates during the oral and early anal-sadistic periods and the way he masturbates later. Perhaps during these first periods the child does not have sufficient concepts or is too unaware of his concepts either to have or be aware of any fantasies. He is only aware of the pleasure in the sensory experience. On the other hand, the content of the masturbation fantasies during the latter

part of the anal-sadistic, phallic, and latency periods and adolescence is either erotic or aggressive, although both elements may be combined at the same time. The erotic fantasies are sensual in nature, and the love object is the parent of the opposite sex if the fantasy is heterosexual and the parent of the same sex if homosexual. Since aggression is combined with the erotic sensual drives, the fantasies will also have a sadistic or masochistic and an active or passive coloring. The aggressive fantasies are hostile and destructive in nature and have as the object one or the other parent.

At first the child is able to accept the conflicting nature of the fantasies without discomfort. As he grows older—say at four or five—the conflicts about the fantasies become painful. How painful is seen in the masturbation fantasies of psychically ill children. For example, a child will obviously be unhappy if his masturbation fantasies consist of thrusting a knife into a woman's breast or of being decapitated by a man. In the first instance, the woman is mother, the thrust with the knife is active and sadistic and would injure the mother if done in reality. Of course, the knife is a thin disguise for the wish to thrust his penis into the mother—a heterosexual drive—and the breast a thin disguise for the vagina, of whose existence he is perhaps not completely certain. Therefore, he keeps the real masturbation fantasy—his wish to have intercourse with the mother—unconscious, but the ideas of which he is conscious are frightening, indicating to him that he wishes to injure the mother whom he loves. In the second instance, the man is father and the fantasy is erotic and masochistic. It is a homosexual fantasy that the father loves him sexually as if he were a woman. That he has such a wish is unconscious. He is conscious only that he wishes the father to cut off his head—actually the head of or his whole penis—and consequently is very frightened. The fantasy itself has a deeper, unconscious part—he would like to cut off the father's head and penis in order to possess the mother for himself—the more superficial (i.e., closer to consciousness) element in the fantasy about his mother. However, he is afraid to allow this hostile fantasy to become conscious lest the father learn of it, cease to love him, and retaliate in kind.

THE CONFLICT OVER MASTURBATION

The severe conflicts between the fantasies themselves, between the fantasies at various levels of the unconscious, between the conscious content of the fantasies and the feelings he consciously has toward his parents, and between the conscious content of the fantasies and the possi-

bility that he might really act them out, produce great mental torture and severe feelings of fear, guilt, and horror. The suffering becomes more than the child can tolerate. He tries to get rid of it by altering his behavior. Since he has the fantasies while masturbating, he comes to regard the masturbation as the *cause* of the fantasies—though actually they are coincidental. Therefore, he becomes frightened of his desire to masturbate and tries hard to stop it. At the same time he tries to deny the fantasies either by repressing them or by thinking of other things. This is why there is partial or complete cessation of masturbation during the latency period and why the child adopts the devices we discussed above to insure masturbating without being conscious that he is doing so. During adolescence the sexual desires, and therefore the desire to masturbate, are increased because of the physiological changes of puberty. This increase reactivates the unconscious fantasies which attempt to break through the repression and become conscious again. This attempt of the repressed fantasies to become conscious is the cause of the adolescent's worry about the effects of masturbation on him. He unconsciously dreads that the old horrifying repressed fantasies will return to torment him or will come true. Too, the conflicts over the masturbation fantasies will be increased if there is the genital inflammation and desire to scratch the irritated parts that we discussed previously. Under these circumstances, the child has great difficulty in ceasing to masturbate and may come to feel that his sexual wishes bring only mental misery but are too strong to resist. And his turmoil is only increased by threats, warnings, or punishments by the parents.

If the boy with the decapitation fantasy were to be circumcised while the fantasy was active, he would become frightened of all sexual feeling. He would feel that his fantasy fear of losing the penis could, after all, come true: having lost part of the penis—i.e., the foreskin—perhaps on another occasion he could lose the whole penis. The loss of the foreskin would act as a warning to behave better in the future. How had he behaved badly in the past? Only in his earlier hostile and aggressive fantasies against the father, which were associated with his passionate sexual love for the mother. He had tried to replace these hostile and aggressive fantasies in his conscious mind by desiring to be the passive submissive recipient of the father's sexual love; i.e., to be the father's wife. He would realize now that the fulfillment of such a wish might entail the loss of the rest of his penis. However, by feeling a passive love for his father he would incur less danger of losing his penis—a loss he would certainly sustain if he were hostile toward him.

The operation, therefore, would make him much more frightened not only of any aggressive drives but also of the heterosexual desires that underlay the stabbing fantasy. As a result, his whole active masculine heterosexual orientation would be repressed and he could allow himself only a passive submissive, homosexual one. He would no longer be able to work through intrapsychically over a period of time his conflicting ideas and feelings about his aggressions and sexuality, to the point where he would no longer be so afraid of them. Instead he would have to repress them so completely that he would be unable to work them through.

Let us discuss here the concept of *working through*. Adult sexuality consists primarily of the gratification of genital sexuality, and secondarily of the gratification, in small amounts, of other impulses—looking, exhibitionism, activity, passivity, sadism, masochism, and the sensual pleasure from the oral- and anal-erotic zones—all combined to further the more important genital gratification. In the child these secondary impulses are not combined to any single end. No single impulse can be gratified partially but demands complete gratification at once, even though such gratification is at variance with the simultaneous gratification of another impulse. The demand for complete gratification of one impulse at one time makes the impulse very hard to redirect. These impulses, which are secondary in the adult sexual life, are all primary in the young child, whose instinct life is disorganized as compared with that of the adult. The *working through* in the sexual life is the process of organizing and directing these impulses toward one goal, which is the ability to gratify them partially in order to increase the capacity to gratify the genital sexuality completely.

THE PSYCHOPATHOLOGY OF COMPULSIVE MASTURBATION

To return to Case 43. The girl's masturbation started at the age of eight months. It began by the use of the thighs and ended in orgasm, as evidenced by marked vasomotor changes and excessive perspiration. I once saw another little girl whose masturbation by the use of the thighs started at four months. She was referred because she was thought to have convulsions. The convulsive movements were accompanied by marked vasomotor changes and excessive sweating, which were really the signs of masturbation ending in orgasm.

Why did these children not use their hands in masturbating? The question is difficult to answer. In the four-month-old girl perhaps the motor co-ordination had not developed sufficiently to enable her to

manipulate the genitals manually. But it can hardly have been the case in the patient who was already sitting up at the age of seven months. The following is another case of masturbating by the use of the thighs. A young adult woman would move her legs during sleep as if she were riding a bicycle, sometimes waking up still doing it. She had no conscious recollection even of thinking of putting her hands to her genitals and on washing herself touched them as briefly as possible. A physician had warned the parents not to let the child touch her genitals, or if she did to be sure she did not touch another person or another part of her body, particularly the eyes, because she had suffered from a vaginal discharge between the ages of two and six which he suspected was gonorrheal.

I have the impression that masturbation by the use of the thighs occurs either because the child is unable to use the hands to masturbate or, more frequently, because he has been forbidden to do so. In the case under discussion there is no history that the child was forbidden to use the hands in masturbation. The drawing of the bird with an umbrella in each hand might indicate that she was unduly concerned about her hands and that there had been some parental restrictions as to the use of the hands in masturbating. Neither is there a history that she sucked her fingers, although her eleven-year-old sister did, and so did her mother until she was sixteen, which also might indicate that there was parental disapproval of the use of the hands.

The answer to the question as to why this child masturbates by the use of the thighs is not so important as the answers to three other questions: (1) Why did the excessive masturbation start? (2) Why does the child continue to do so openly and even to draw attention to it, although she has been punished fairly severely for it? (3) Why does she not show shame or guilt about it?

She is a child of an unhappy marriage. The parents are hostile toward each other, even to the point of occasional physical violence and long periods of silence. They have not separated because they believe it would be bad for the children. Both parents are unstable and readily fly into tempers. As a result of this atmosphere of quarreling (which the patient has witnessed many times and which has obviously frightened her) and unhappiness, the patient has developed great anxiety, which she expressed by her constant crying and insomnia as a baby and by her panic when the psychiatrist in the first interview tried to see her alone. Her masturbation, therefore, must be a means of quieting her anxious feelings. Frightened by the turmoil around her, she could dis-

regard it by concentrating on the pleasurable sensation produced in the genitals. The anxiety would be a combination of fear—because of the violence around her, fear lest she be the cause of it, and lest she be injured, destroyed, and not loved as a punishment—and anger and rage because she felt so uncomfortable and yet too frightened to express her annoyance openly. Her hostility was stimulated further by the fact that her sleeping in the parents' bed was stopped at eight months—just before the masturbation began. This seems to have been the straw that broke the camel's back.

Her masturbation expresses fantasies, some of which are conscious and some unconscious. These fantasies also appear in her play with the psychiatrist:

1. A desire to separate the parents.
2. Hostility toward the siblings. Of this feeling she is almost completely conscious, and she acts it out.
3. Her unsatisfied oral cravings.
4. A compensation for her feeling of inadequacy.
5. Ambivalent feelings toward father, mother, aunt.

All these fantasies and feelings are associated with the act of masturbation and so find expression in it. In this, the little girl is no different from any other child, for the masturbation of all children—at least over the age of two years—is accompanied by fantasies and serves as a means of expressing feelings and ideas.

Why does she continue the act even though some of the fantasies are unpleasant and even though she has been punished for it? I have spoken of the fact that a child usually tries to stop masturbating if he is punished for it or if the fantasies become too painful and frightening. One of her outstanding characteristics is her desire to obtain reactions from others, particularly adults, as evidenced by her behavior with the psychiatrist and by her stories to him of her behavior toward the adults in her home. But she desires a particular type of attention: she wants the adults to disapprove of her. This seems strange, since disapproval is usually very unpleasant. She is able to disregard the unpleasantness, provided it does not become too painful, because she gets a pleasurable thrill from the masturbation. In addition she gets a further thrill. A mischievous child does something he knows will meet disapproval and then slyly and with a laugh draws attention to the act; he gets a kick out of seeing how far he can go. Many children are like this. They like to live dangerously, i.e., always in a situation where there is a thrill. Thus the patient masturbates in front of adults in order to get a thrill. Her masturbation,

therefore, is associated with and expresses certain other fantasies which are unconscious:

1. A desire to attract attention, i.e., an almost conscious exhibitionistic fantasy. The family is quite enthralled with her contortionism and back-bending. She derives pleasure from exhibiting her acrobatic skill, at the same time getting pleasure from the bodily movement and from the pressure of the thighs on the genitals.

2. An attempt to seduce the adult to give her sensual pleasure. The masturbation is a magical gesture done in front of the adult to induce him to touch her genitals. This fantasy is unconscious and the patient defends herself against it not only by repressing it but by regression.

3. She regresses from the phallic fantasy of having her genitals touched by another person to the anal-sadistic fantasy of having another person treat her cruelly. Part of this fantasy is conscious: she desires the thrill of danger, and any child can put herself in a position of danger by defying an adult. Part is unconscious—i.e., the desire to be treated cruelly. This masochistic feeling toward adults accomplishes two purposes: it assuages her feeling of guilt about her masturbation and masturbation fantasies, and it gratifies her anal-sadistic needs.

4. A sadistic feeling toward adults—as with the psychiatrist. She wishes to humiliate them and to crow over them.

It is the presence of those sadistic and masochistic fantasies—an accentuation of the anal-sadistic stages of development at the expense of the phallic phase—that distinguishes this child's masturbation from ordinary masturbation and that puts it in the category of a perversion instead of a normal act.

Ordinarily because of the painfulness of some of the masturbation fantasies, the child develops a sense of guilt about the act and tries to stop it. Why does this child masturbate openly as if she had no fear or guilt about it? She has learned to get a thrill out of her feelings of guilt and so can disregard them. Her behavior does bring punishment. She is constantly drawing attention to certain acts—such as coming late, bossing the psychiatrist, demonstrating her masturbation—which she knows will annoy and irritate the adult and make him angry with her. This attempt to get punishment serves as a means of assuaging temporarily her feelings of guilt. (I will discuss this need for punishment to assuage a sense of guilt later in another connection.) She also projects her sense of guilt through a phobia—she has a neurotic fear of germs.

There is, therefore, a further fantasy in her masturbation: by being

bad openly, she will be punished and will then feel less guilty. Thus she uses the act of masturbation, which makes her feel guilty, for the purpose of obtaining punishment to assuage her feeling of guilt.

Her diagnosis, therefore, is one of compulsive masturbation, which is a perversion.

THE DIFFERENCE BETWEEN COMPULSIVE AND ORDINARY MASTURBATION

Compulsive masturbation differs from normal masturbation clinically and in its fantasy content. As in this girl, it is often performed openly and the attention of the disapproving adult world drawn to it. (This in itself does not constitute compulsive masturbation. Its open performance may simply be an expression of exhibitionism.) It is performed as if the supply of sexual desire were inexhaustible, and therefore it is not associated with real pleasure and satisfaction, as is ordinary masturbation. In fact, there is often no real pleasurable feeling connected with it. As we have seen, the patient's fantasies are not erotic ones but have purposes other than pleasurable gratification of sexual desire. Their latent content is often of a pregenital nature. No matter how often the act is performed, it can never satisfy this type of fantasy need. This child shows the beginning of a tendency often found in older children and in adults: she draws the attention of the adults to her masturbation in order to get their disapproval and punishment. Older children and adults may masturbate compulsively as an attempt to hurt and injure themselves, i.e., to castrate themselves. This predicates an apparent contradiction. An act that originally gratifies erotic desire and so is condemned has now become a means of punishment for the desire to masturbate. It is as if the person said, "I must not masturbate because it is forbidden to me to get pleasure from it, so I will stop. But I cannot stop; therefore, I will masturbate to punish myself by self-injury for wanting to masturbate." In this way an instinctual desire is experienced by the person as a superego command.

The treatment for this child's symptom obviously will not be one of trying to stop the masturbation by advice, threats, or punishment. Only by psychotherapy will she be able to recognize and resolve the sources of her anxieties. At the same time, it is necessary to attempt to solve the serious emotional problems in the home. These problems affect the child directly by causing her to feel anxious. They affect the attitudes of the parents toward the child and their management of her.

There is an important point to discuss about the marital discord.

These parents would like to separate but instead stay together for the sake of the children. Parental discord has a very traumatic effect upon the development of the children in the home. So too does parental separation, perhaps more so. When discordant parents remain together for the sake of the children they tend to vent their mutual hatred against the children, whom they come to regard as the chains that bind them together. One parent may attempt to claim all the child's loyalties for himself by instigating a hatred in him for the other parent. Such situations frequently found in the childhood of adult neurotic patients result in serious injury to the person's psychic development and produce great difficulties in his future ability to make a successful adjustment.

PSYCHOSES IN CHILDREN

SCHIZOPHRENIA is the most common type of functional psychosis in children. The schizophrenic child has difficulty in adjusting himself to all phases of his life, and because of this withdraws his contact from people and from reality.

CASE 44. An eleven-year-old girl is referred because of her strange behavior. She pays no attention to other children and does not join in their games. She has never attended school; her mother teaches her at home after a fashion. She has never really learned to read, write, or work with numbers. She pays little attention to her parents, ignoring her father and usually also her mother. However, if her mother refuses her, she yells, shrieks, spits, is profane, and repeats her demands over and over. She likes to ride in a car and has an extremely accurate memory for places, directions, and people both by appearance and by name. She has an excellent ear for music and amuses herself by playing accurately on the piano music she has heard only once. She also likes her mother to play for her.

She is restless and spends much of her time running from place to place. She has difficulty concentrating. Her mood seems usually to be a happy one, but sometimes she wears a puzzled expression, and at other times she looks depressed and unhappy. She talks in a rather high-pitched voice. Her speech is clear, but she is not conversational. She has difficulty in the use of pronouns, particularly "I" and "me." If she wants a piece of candy, she usually says, "Do you want candy?" and whenever she uses the pronoun "I," she does so with visible effort, succeeding only after several incorrect starts. She teases a great deal and tries

to get the adult to repeat after her an incorrect statement so that she can laugh heartily at him and point out where the statement is wrong. She recognizes when an act has been forbidden or is undesirable. Even though the reasons for a prohibition have been explained to her, she violates it with the hope that the adult will object. She tends to repeat what is said to her in order to get the adult to repeat what she has said. This attempt to get pleasure from being talked to comprises most of her conversation. If asked, "Why do you want water?" she replies, "From the spigot." When the question is repeated, "Why do you want water from the spigot?" she replies, "From the spigot in the bathroom." When something is said to her, she seizes upon one word or one phrase and repeats it in reply. All of which would give the impression that she has not understood perfectly, which is not the case.

Often she reacts to frustrations and deprivations by becoming more happy, more smiling, and extremely restless, while her voice becomes more high-pitched, and by doing a number of forbidden things. At other times she reacts by shrieking, yelling, and swearing.

She puts all kinds of objects—clean or dirty—in her mouth, and sucks, chews, and swallows them. When the object is dangerous, she puts it in her mouth only to upset and alarm an adult.

Routines are all-important in her life, and once she has learned one, she does not deviate from it. If anyone or anything forces her to change it, she becomes annoyed and either has a temper tantrum or becomes markedly restless. She does odd jobs about the home, and having learned to do something, she carries it through well. She eats and sleeps well and is moderately neat and careful of her appearance.

At the age of four, her behavior was as peculiar as at eleven. She was restless and overactive and showed no sustained interest in any person or thing. Whenever she was spoken to, even by her mother, she paid little or no attention. She would not object at first to a stranger and might even answer a few questions, but in a few minutes, when she noticed that the person was a stranger, she would cry and insist that her mother take her away. Although she had books, dolls, and toys, she rarely showed interest in them but spent most of her time in endless and seemingly aimless running. Five minutes' piano playing and singing was the longest she pursued a single activity. She would insist that her mother play the piano, the patient sitting quietly in a little rocking chair and her facial expression changing as if she were in an entirely different world (resembling a case of catatonic dementia praecox responding to auditory hallucinations or a person in a trance); external

stimuli that might be disturbing to another child did not affect her in the least. She recognized all the pieces and would hum them or sing the words. Afterward she would go to the piano and play the same tune, using both hands. Her chords had excellent harmony for a child her age. She was very distractible, spending her time going to the piano, looking at her doll, picking up a book, running back to the piano, running boisterously through the rooms, starting to cry, going to her mother, having a temper tantrum, and then starting to dance. When given pictures to look at, she would dance around for the few minutes that she looked at them.

Her speech at this age was difficult to understand because she used only broken, irrelevant sentences. Usually she talked to herself. Although she paid so little attention to her surroundings, she showed clearly that she was very aware of them. Her temper tantrums occurred when there was any change in routine. I saw one. Approximately twenty minutes after I came, she asked her mother to put her sweater on but was told it was not necessary. A few minutes later she asked to go downstairs, being accustomed to go riding about this time. I explained that this could not be done. She left to play the piano, but soon reappeared crying, yelling, and attempting to pull her mother away. When asked what she wanted, she said, "I wanna drink. I wanna drink." Her mother explained that this was her persistent request during a temper tantrum, but that she always refused one when it was offered. She mumbled to herself, "I didn't do it," several times during the course of the tantrum. The mother could not give any reason why she said this. She came over and attempted to pull her mother from the chair and took rapid running steps in place on her toes, flapping her arms at the same time. The most noticeable characteristic was the extremely rapid running steps with her legs very close together. During this activity, she stood tense in one place and gave the impression that she could not consciously stop the movements. She never seemed to tire. Throughout, she gave the impression of being in terror. She cried a little. The tantrum continued for the fifty minutes that I was there and showed no signs of termination when I had to leave. The mother described two interesting examples of tantrums: (1) She was accustomed to having her bath after dinner. One day she was bathed first. In the middle of dinner, she began to cry and scream for her bath. (2) The mother was accustomed to return home about 5 P.M. Although the child could not tell time, at about 5 P.M. she would start running to the door. If the mother did not come, she would cry while running to and fro. When the mother did come, she paid no

attention to her but stopped crying and returned to her usual aimless restlessness.

A psychometric examination was, of course, impossible, but the psychologist gave her the following ratings: On the Vineland Social Maturity Scale she received a social age of three years and eight months, eleven months below her chronological age. Those activities involving self-help, communication, and socialization were more poorly performed than occupation and locomotion. Speech was underdeveloped for her age and pronunciation poor; often phrases were used instead of sentences; her speaking vocabulary was small for her age; no estimate could be made of her abstract vocabulary. Her memory in general, and particularly for music, was excellent. She was able to recite poetry which the mother said she had never been taught. Motor co-ordination was well developed in those tasks she did perform; however, very few of her activities involved very fine co-ordination. Although she ignored persons in her environment, she was most observant of objects, either commenting on them or handling them.

Six months later she had changed only slightly. She wandered aimlessly from one part of the room to another and was very distractible. When spoken to, she did not listen. Her eyes never appeared to be fixed on any one object except when her mother was playing, at which time she stared off into space as if enraptured. She still walked on tip-toe most of the time. Her vocabulary had increased, though it was difficult to judge whether it had increased by the normal amount because she was so un-co-operative. Most of her speech was the exact repetition of what her mother had said or was in phrases that one would expect from a two-year-old. Whenever she was asked to do something or was about to do something, she insisted on her mother repeating the command as if to reassure her. For example, when the mother asked her to put the blocks away, she kept repeating, "Put the blocks away, put the blocks, A., put the blocks away"—until the mother was forced to say it too, whereupon the patient complied. She did not co-operate on any of the formal tests. In fact, she did not even play with me for more than a minute at a time, and toward the end of the visit she refused even to look at me.

The reports from nursery school described similar behavior: The patient went to the fence, looked out for a minute, then walked up and down the center line keeping her eyes on the ground. She kicked the ball for a few minutes, then walked in circles, twirling herself around. She pushed a truck for half a minute. She saw a child throw a ball and

ran in its direction. She saw some other balls, picked one up, and played with it for three minutes, dropping it on the ground and running after it. When she tripped she cried, got up, and began to wander aimlessly. She walked back and forth on planks, then half ran away, shaking her head. She dragged the doll carriage backward, pulled it up the step and pushed it down. She asked a teacher a question and pulled the carriage away. A minute later, she approached another adult and was taken to the toilet. She came back and pushed the carriage back and forth over a board. She heard a train and ran to the fence, looked at it, then returned to the doll carriage and held it as she watched the other children play "parade." She walked to the end of the roof, got on her knees, and crawled a few feet—then on all fours. She got up, walked about aimlessly and when she reached the boards, she straddled them as she walked along. She lay on the board, rolling back and forth, was still for a second, then wiggled. She got up and walked to the fence, looked at the ground, then up to the bell as it rang, swinging her arms as she did so. She did not mingle with children at any time but gave them her toys and completely ignored them.

The patient appeared to like a teacher who was with her for a long time. The first three or four days she spent indoors. She seemed interested in the telephone. She lifted the receiver and said, "Hello, just a minute, just a minute, okey-doke." Then she put the phone down and ran around the room aimlessly. After a few days indoors, she went out to the roof. No toys interested her, and she ran around the roof most of the time. After a few days, the patient ran to the incline-board of the climber, put her foot on it, and ran away. She came back at intervals and tried it again, each time seeming more sure of herself, until finally she took a step, then two. After she became used to standing on the board, she sat down on it and shook it, and was so pleased with the result that she kept it up. The first toy with which the patient played was a ball. She would pick it up, throw it down, and run after it. At first she played only for a minute, but gradually she played with it longer—but never for more than five minutes. Between periods of play with the ball she would run around the sides of the roof, holding onto the fence. Once in a while she would put her hand on a kiddie car or coach. When a student teacher or child attempted to talk to her, she would run away. If an adult picked her up, she would feel the person's hair, face, the buttons on her dress or coat, and her fingers. She talked little but made sounds that did not resemble words. Because she liked to jump on the board as well as to bounce, she soon began to approach the student

teachers so that they could hold her hand as she jumped. As she did this, she laughed and shouted with joy. Once when she was running around the roof the teacher told her to sit on the rug on the step. The teacher put a hammer in her hand and gave her the Bingo Bed, showing her how to hit the pegs. She watched very attentively and then reached out for the hammer. She played with it a few minutes, but noticing other children gathering around her, she put the hammer down and ran away.

When playing outdoors she did not like to wear gloves. If she had them on, she chewed them. She preferred little or no attention. If the teacher picked her up, talked to her, and laughed, she would laugh, too. Once she had started to laugh, she would keep it up for some time. Sometimes she would respond if someone called her name. She mostly ran around the room on her toes or danced. Although she did not bother with the other children, she might stand and watch them. She repeated phrases spoken by others rather than attempting to make a statement herself. If someone said to her, "You are playing in the sand" or "This is paper," she would remember the simple phrases and repeat them when she saw the objects again. The patient seemed to have some initiative but would usually roam around the room without deciding what to do. After a period in school she became more co-operative in dressing and undressing, toileting, and eating. If she was restless and the teacher played a song she knew, her restlessness would stop as she became interested in listening or humming it; she would respond thus even when in another part of the room. She used the hollow blocks as a seat. When she used crayons, she would put her head down close to the paper to make sure she could see the color. She was unpopular with the children, so all her play was solitary. At nap time, she could not keep her feet still. She snored. When she first came to school, she sucked her thumb.

History. She was an only child of a professional couple. The pregnancy was full term; her birth was about the usual length, and no instruments were used. As far as can be ascertained, there was no anoxia. She was breast-fed for eight months. Before she was born, the father laid down an absolute rule that the child should not be touched, looked at, or spoken to except when the routine demanded—in order that the child should not be spoiled. Both parents adhered strictly to this rule. When the child was fifteen months old, the mother returned to teaching and the child was left in charge of a succession of maids, on whom the father imposed the same rules. Her toilet training was effectual at about

two years. Her temper tantrums started during a vacation when she was about two years of age. She awoke from a nap, saw some strange people, and immediately had a temper tantrum. When she was three, the mother began to notice that there was something wrong with the child and put her in a nursery school.

Examinations. Her physical condition was excellent. There were no signs of any organic cerebral lesion.

It was never possible to do an adequate psychometric examination. Her behavior resembled that of a much younger child, but I felt certain from my contacts with her that she had at least average intelligence.

It required a number of interviews to obtain any degree of rapport with the patient, and even that was achieved in part by giving her candy and gum at each interview. She played mostly with water. I should say worked: she would get a pail of water and a cloth, sprinkle sand from the sand table on the floor, and proceed to wash the floor. When the water became somewhat dirty, she would carry the pail to the bathroom and empty it in the toilet. Taking a piece of toilet paper, she would wipe the sand out of the pail. Usually she would have put about half a pound of sand in the pail so that in wiping it out, she would have large lumps of wet sand on the paper. She would look at the sand, smell it, call it bowel movement—that was the name she used—throw it and the paper into the toilet, and flush it away. Sometimes she would express disgust or have to spit in the toilet during the performance. After all the sand had been thoroughly removed from the pail, she would continue to clean it, using small pieces of wet toilet paper. When it was completely clean, she would allow it to fill under the faucet, emptying the water out a number of times. When she seemed satisfied that the pail was clean, she would refill it with water and proceed to scrub the bathroom floor. She always dirtied or wet the floor before she washed it. She often talked of the fact that the water got dirty. Her washing resembled the work-play washing of a much younger child. She did not wash the corners of the room, nor was the washing very effectively done. She would plug the outlet in the basin with a piece of carefully torn-up rag, turn the water on full, and allow it to run over the floor of the bathroom. She would then spread a cloth carefully over the drain in the floor and allow the water to collect in a pool.

Occasionally she would vary this procedure by taking a cup, placing in it a spoonful or two of sand, and adding some water, stirring carefully, stating that she was making sauce or gravy. This, in contrast to the washing, was play.

Each day she came to the playroom, she would say, "Do you want water?" meaning I was to ask her if she wanted water. Occasionally, however, if I paid no attention to her, she would struggle with her difficulty with the pronouns. Only after great visible effort could she say, "I want water." If I said something to her, she would try to get me to repeat my statement—usually by repeating the first part and pausing in the hope I would finish the sentence. Often she would try to get me to make statements forbidding her to do something. Sometimes she would mention a person's name, and when I would ask who the person was, she would simply repeat the name. Later she might repeat my inquiry: "Tell me about Dorothy."

Her teasing was marked. As soon as she learned that a particular act could not be permitted because of hospital rules, she would attempt to do it in order to get a reaction from me. None of the acts were really malicious or harmful. At times, though, the situation became rather difficult to handle; for example, she would leave so much water on the bathroom floor that it began to run out into the hall, when I would be forced to interfere. Soon afterward she would try to do the same thing, with the laughing, rather sly facial expression of the teasing child.

After rapport had been established, she became extremely fond of me. She would stand watching for me to take her to the playroom and would literally dance when she saw me. She always knew the day and time of her appointment and sometimes had to remind her mother that she would or would not see me on a certain day. She liked to sit on the arm of my chair and nibble gently at my ear. Whenever I found it necessary to tell her I had to break an appointment with her, she would find occasion to tell me that she was going to see me on the very day I had to be absent, partly in order to deny the reality of my absence and partly with the teasing hope that I would correct her. At such times she would be more active and more excited; she would talk in a higher-pitched voice, and the teasing would increase greatly.

Diagnosis. This child's peculiar behavior may be summarized as follows: She had more real relationship with routines and time than with human beings. Adherence to routine gave her greater libidinal comfort than did closeness to a human being; she developed more anxiety when separated from the routine than when separated from a human being. Although she could love another person, as was plainly evident in her relationship with me, her love expressed itself as an attempt to be me, identifying with me rather than loving me as a prepubertal girl loves a man. Furthermore, in identifying with me, she did so with the prohib-

itive side of my personality; i.e., with an aggressor. This type of identification love made it difficult for her to make a valid and useful relationship with other people; it interfered markedly with her capacity to carry on an intelligible conversation or to learn the skills necessary for her existence as a separate person. Her libidinal relationships, as well as her interests, were at the anal sado-masochistic level. Her behavior during therapy expressed many fantasies, but because of the difficulty in verbal exchange it was hard to understand them. Of course, she showed many oral trends and a few genital ones; e.g., she masturbated occasionally. On the basis of her behavior, I would diagnose her as psychotic and her psychosis as schizophrenia.

SCHIZOPHRENIA IN CHILDREN

Bradley¹ classifies psychoses in children as follows:

1. Symptomatic; i.e., the result of physical illnesses.
 - a. Delirium as the result of febrile illnesses.
 - b. Psychoses as the result of ingestion of drugs.
 - c. Psychosis associated with chorea.
 - d. Psychosis associated with convulsive disorders.
2. Functional.
 - a. Schizophrenia—the most common.
 - b. Manic-depressive psychosis. This is extremely rare. It is questionable if it ever occurs in childhood.

He has four criteria for the diagnosis of schizophrenia in children.

1. The presence of true psychotic reactions.
2. The presence of disturbances at every level of adaptive function.
3. The presence of a fundamental pattern of withdrawal.
4. The presence of a reliable history of difficulties in adaptation in the earliest years of life.

Bender² defines childhood schizophrenia as a "clinical entity occurring in childhood before the age of eleven years which reveals pathology at every level and in every area of integration or patterning within the functioning of the central nervous system, be it vegetative, motor, perceptual, intellectual, emotional or social. Furthermore, this behavior pathology disturbs the pattern of every functioning field in a character-

¹ Charles Bradley: *Psychoses in Children. Modern Trends in Child Psychiatry*, International Universities Press, New York, 1945.

² Lauretta Bender: "Childhood Schizophrenia," *American Journal of Orthopsychiatry*, 17:40, 1947.

istic way. The pathology, therefore, cannot be thought of as focal in the architecture of the central nervous system but rather as striking at the substratum of integrative functioning or biologically patterned behavior."

The author goes on to say that in every schizophrenic child "there are disturbances in the vaso-vegetative functioning; the physiological rhythms of daily living lose their normal rhythmic pattern; there are characteristic disturbances in patterned motor behavior and motility, and early or primitive reflex patterned activities outlive the stage to which they belong. The normal child up to the age of six years will turn his body to bring it into line with the head if his head is turned on his neck by the examiner while he stands with arms outstretched in front of him and his eyes closed. The schizophrenic child responds with a graceful fluid whirling which he accepts quickly as a new pattern of activity. There is a physical and bodily dependence demonstrated by physical contact as if the child would melt into the body of the adult. There is a cohesiveness of the body surface. It is possible to obtain complete motor compliance by contact with the palmar surfaces. The child can be pushed about at will. The schizophrenic child of three to six years if left to his own devices carries on endless rhythmic and graceful dancing behavior with changing tempos. He has darting impulses, also. There is an uncertain contour of the facial musculature which leads to carefully patterned grimacing. He is unable to care for his bodily secretions, bodily extensions and his clothes."

She believes "that the characteristic pathology of schizophrenia is an impulse to active and reactive anxiety with a desire to understand and correct this pathology. This combined with the accelerated creativeness of the child of six to twelve years makes the schizophrenic child often show remarkable artistic ability in graphic arts, dancing, music and verbalization. His drawings of the human figure show a multiplicity of heads and limbs, facial expressions of anxiety and terror, feelings of external influence and changing states of consciousness, interpersonal relationship and social problems.

"When schizophrenia develops before language is well established, there is usually more or less retardation, inhibition and blocking. Speech gradually may deteriorate into the use of simpler language forms, dropping out of connecting words and loss of more recently acquired language forms. Language is not used as means of communication but may be used as a repetitive expression of anxiety in which questions concerning identity and orientation are asked and for which no answer

is awaited. The third person pronoun for the self is used and all other pronouns may be avoided. If the child before he develops schizophrenia has mastered language, he may show an increased activity in the field of language and in thinking processes. The significant psychological problems of childhood schizophrenia are those of identity, of body image and function, of object and interpersonal relationship, of orientation in time and space, of the meaning of language and of anxiety. The essential psychological problem is the difficulty in recognizing one's self and one's thinking in relation to the rest of the world. This difficulty produces severe anxiety and the symptom formation is an attempt to do away with the anxiety. There may be excessive and open masturbation and preoccupation with the functions of elimination. Anxiety is the nucleus of the schizophrenic problem in the earlier stages. It is the reactive mechanism of a personality threatened by the disrupting effects of the schizophrenic process.

"Often one can make an unusually good contact with schizophrenic children, in contrast with schizophrenic adults. They are attractive, intriguing and appear gifted but they have searching, penetrating, aggressive and clinging dependence."

In the diagnosis of childhood schizophrenia, the most important factor is the age of onset of the illness, and the second is the degree of severity and rate of progression. Bradley and Bender do not mention hallucinations and delusions in considering the diagnostic criteria, which two groups of symptoms are signs of an attempt at recovery, rather than of the presence of the illness. It is my belief that hallucinations and delusions do not occur in childhood schizophrenia until late in the latency period or in adolescence. With this concept, the majority of authorities agree. The symptoms in the case I have reported agree with Bradley's criteria. The history, however, is not typical of all cases of childhood schizophrenia. Some time ago I saw in consultation a boy of four.³ He was tall for his age, his features were finely chiseled, and this, associated with an expression of alert happiness, made him a very handsome boy. He paid no attention to me when I was introduced to him, and he entered the playroom with his father without hesitation. When left alone with me he continued to pay no attention to me. He climbed on the window sill and sat there patting and licking the rounded edge of the window embrasure and talking to himself in an unintelligible language. This behavior, including the sound of his conversa-

³ I am indebted to Dr. Samuel Guttman for the opportunity of examining the patient and for permission to include a description of him.

tion, was precisely that of a three-months-old child nursing at the breast. After a while he got down, went to the locked door, and tried the handle, after which he resumed his previous occupation. On climbing upon the window sill, he slipped and the side of his foot hit the edge of the table. This foot had been burned badly on a radiator the day before. He paused for an instant and then climbed up. At no time did his facial expression of happiness change, although his foot must have hurt and he must have been frightened when he found the door was locked. I took him out to the nursery-school playground, where children his age were playing. He paid no attention to them, to me, or to his father when he came to take him home. Dr. Guttman told me that during the four months he had been seeing the patient several times a week, his behavior was the same as I have described. The boy had developed normally up to about one year before Dr. Guttman saw him and was, in fact, somewhat precocious. He walked and talked early; by the time he was three he was beginning to read and to be very interested in playing records on his own record player. His whole behavior and ability changed in the space of one month and became that which I have described. He lost interest in reading and music, and his language became unintelligible. Two episodes occurred shortly before the change began. His grandfather, in playing with him, slipped, fell, and hurt his arm. His aunts thought he had too many toys and persuaded his parents to give most of them away to a charitable organization.

This case is similar to one reported by Rossman:⁴ "A natural and normal child was separated from his parents for a great part of his second year because of the mother's grave illness, and during the ensuing year, his life was further disrupted by his own illnesses, including otitis media and tonsillectomy. He resisted learning to feed himself; he resisted bowel training. Between two and a half and three years of age he developed obsessions and compulsions. He stopped talking, although he would occasionally mumble his first name or sing spontaneously. He played alone by the hour. He was heedless of danger and showed no fear. His facial expression showed signs of pleasurable fantasy. When I first saw him at three and a half, I thought he had auditory hallucinations. He had been taught to feed himself and to carry out simple tasks. At six he began to talk again but used baby talk, sang nursery rhymes, and repeated his baby sister's name; his speech

⁴ Max Rossman: "Childhood Psychoses: the Therapeutic Problem." Read before the meeting of the Pennsylvania Psychiatric Society, April 10, 1941.

was predominantly echolalic. Autonomous rage reactions occurred frequently, during which he raced about heedlessly and purposelessly, screaming and making biting and chewing movements not directed toward any object. The whole reaction showed an incomplete affect."

These last two cases differ from Case 44 in that the children developed normally for a period of time and then suddenly became psychotic as the result of a traumatic experience. In my case, there seems to have been no sudden onset. I believe there are three types of schizophrenia in children. The first type has a gradual onset; the second has an acute onset following a traumatic experience, the symptoms in both types being similar and the schizophrenia developing during the prelatent period; the third type begins in the latter part of the latency period, the onset being gradual and the symptoms often more paranoid in character.

Psychopathology. We will recall our patient's outstanding characteristics—a libidinal relationship with routines rather than with persons, an adaptation at the anal-sadistic level of psychosexual development, and an almost total inability to communicate verbally. When a libidinal relationship with a person occurs it takes the form of an identification, usually with the aggressor. The patient felt secure only in relation to activities such as music and, more particularly, to routines. When any change occurred in her routine, she reacted with great anxiety, as if the frustration made her feel insecure. Her insecurity made her feel anxious, and in order to assuage this feeling of anxiety she turned to her only satisfying experience as a baby: she demanded water because as a baby the only time she got attention was during feeding and other routines. The outstanding known etiological factor is the isolation to which she was subjected during the first year or so of life. These reaction patterns are the results of the training. Benedek⁵ says, "Quite different from normal development is the adaptation to reality in those children whom we describe as affected by hospitalism, lack of love, or by too much routine. These children cannot establish confidence through a primary object relationship and they develop a greater amount of anxiety with which they have to contend. This anxiety has several sources. One of them is the body itself which causes the infant pain by traumatic sensations of unsatisfied instinctual needs. The other source of anxiety is the real danger in which the weak ego finds itself in the object world. Perhaps we could assume as a third source at a later age the instinctual tension which develops as a result of the disturbance of the object

⁵ T. Benedek: "Adaptation to Reality in Early Infancy," *Psychoanalytic Quarterly*, 7:200, 1938.

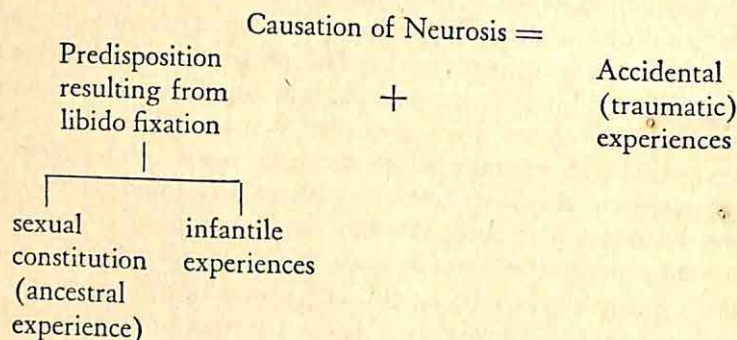
relationship to the mother. Whatever the source of the anxiety, it is clear that it is a heavy burden for the little ego to deal with. The ego, beset by the anxiety, turns only to a small part of the object world, cannot select and learn, but reacts with a rigid adaptation. Such reflex adaptation saves the child from an increase of tension and is helpful in the avoidance of anxiety; but every new situation, in contradiction to the old ingrained reflex, will be experienced again by the weak ego as a danger to which it cannot adjust itself immediately but to which it reacts with crying, the discharge of a fear reaction. There is another reaction which also is possible—avoidance of fear by a refusal to accept a new situation. Both these reactions, crying and rejection of the new situation, restrict the ego's capacity to adapt itself to reality."

In our patient the second type of reaction—i.e., the avoidance of anxiety by a refusal to accept a new situation—was the stronger, causing the child's ego to turn more and more away from reality and making her less and less able to develop adequate and satisfying relationships. Left alone to cry when hungry, in pain, or uncomfortable, and picked up and attended to only at specified times, she was constantly subjected to pain and frustration. These unpleasant feelings aroused great waves of anger and hatred which in turn caused her to feel more anxious. In order to avoid this anxiety, she projected her feeling of hostility onto her environment, which increased her fear of the hostility of her surroundings. Starved for affection and physical attention, unable herself to relieve the pain of her own unsatisfied desires and fearful of her hostilities as well as those of the environment, she made an adaptation by looking forward to relief at routine times, by withdrawing from difficult situations, by refusing to enter into new ones—particularly those that meant a change in routines—and by making a strong identification with the fantasied hostile adults of her world. This strong identification—made for the purpose of relieving anxiety—became the most prominent mechanism in her life. She became fixated on it and so found it impossible to progress toward a more effective type of object relationship. She dreads to relinquish any of these mechanisms lest she expose herself again to the early frustrations and anxieties. She dreads, also, to allow herself to react to frustrations by hostility lest she be destroyed by the counterhostility of the environment, a feeling that is partly realistic and partly projected.

Behind the mask of indifference, apparent happiness regardless of outside stimuli, and strenuous clinging to her form of adaptation—inadequate though it seems to us—this child is a shivering mass of infantile fear of which she is not conscious. Every psychiatrist who has

studied schizophrenia either in adults or in children is aware of the intense anxiety, whether conscious or unconscious, suffered by the patients and of the fact that so many of their symptoms are defenses against this anxiety. Anxiety is simply a signal of danger. What is the danger the patient fears? He dreads the strength of his own instinctual drives. As Anna Freud says,⁶ "If the ego feels itself abandoned by protective higher powers (superego or parents) or if the demands of the instinctual impulses become excessive, its mute hostility to instinct is intensified to the point of anxiety." What is the danger that the ego fears from the instincts? Freud⁷ was not sure. He says, "We know it is in the nature of an overthrow or extinction." Waelder⁸ believes it is the danger that the ego's whole organization may be destroyed or submerged.

Etiology. Each of the three children we have been discussing in this chapter has had traumatic experiences, those in Case 44 being the most severe. But many children undergo similar experiences without becoming psychotic. Why, then, did these? We do not know exactly. The reason seems to lie in the constitutional make-up of the child. Freud⁹ gives the following formula for the causation of neurosis:



⁶ Anna Freud: *The Ego and the Mechanisms of Defense*, p. 63, Hogarth Press, London, 1937.

⁷ Sigmund Freud: *The Ego and the Id*, fourth edition, Hogarth Press, London, 1947.

⁸ Robert Waelder: "Das Prinzip der mehrfachen Funktion," *International Festschrift für Psychoanalyse*, 16:287, 1930.

⁹ Sigmund Freud: *A General Introduction to Psychoanalysis*, p. 316, Liveright Publishing Corp., New York, 1935. If the reader is interested further in understanding Freud's concepts of the etiology of the neuroses, he will be helped by reading the whole of Chapter 23, "The Paths of Symptom Formation."

This formula, if applied to the causation of psychosis, is weighted heavily on the side of sexual constitution (ancestral experience). I believe it is this constitutional factor that makes it difficult or impossible for the schizophrenic individual to adjust to his instinctual life and that Bender calls "the schizophrenic process." Of course, in bringing in the concept of constitution as an etiological factor, one has to be careful not to place too great emphasis on it to the exclusion of the effects of prenatal and early postnatal experiences. Levy¹⁰ has drawn attention to the serious and apparently irreversible effects of libidinal starvation during the first year of life, and Greenacre¹¹ has described a type of patient whose extreme degree of anxiety seems to be the result of excessive prenatal stimuli. It is only when the effects of all post-conception experiences can be excluded that we can be justified in looking to constitution as a specific cause. In sum, the psychoses seem to be the result of constitutional peculiarities that make the individual unable to tolerate traumatic experiences to which other persons, not so constitutionally incapable, can adjust. However, the whole question needs a great deal more extensive and intensive study, with more delicate methods.

There is no way of estimating how frequently schizophrenia develops in children, but I believe it occurs more often than is recognized. Many psychotic children, particularly when the psychosis develops fairly slowly and at an early age—i.e., within the first four years—are diagnosed as feeble-minded on the basis of their apparent inability to learn and their inadequate responses on psychometric examination. I believe—and in this belief I am supported by such authorities as Dr. G. Henry Katz, who has had much experience with feeble-minded children—that every school for such children contains a certain percentage who are not feeble-minded but schizophrenic.

PROGNOSIS OF CHILDHOOD SCHIZOPHRENIA

I have not had sufficient experience to state definitely what the ultimate outcome of such cases as I have described in this chapter will be. Some make attempts at recovery through the development of hallucina-

¹⁰ David M. Levy: "Primary Affect Hunger," *American Journal of Psychiatry*, 94:643, 1937.

¹¹ Phyllis Greenacre: "The Predisposition to Anxiety," *Psychoanalytic Quarterly*, 10:610, 1941.

tions and delusions and are committed to institutions for custodial treatment. Some remit through a process of apparent intellectual retardation and remain this way for the remainder of their lives. Some follow the same course as this second group but eventually develop more or less acute psychotic episodes. Others may remain as they are without any change. I believe, however, that the resurgence of instinctual—specifically sexual—drives at puberty must produce either a heightening of the existing defense mechanisms or new defenses whose main aim is that of withdrawal from reality.

Schizophrenic children are constitutionally not capable of profiting from the usual environment. They present extreme difficulties in management at home, and they cannot adjust to the ordinary school situation. They develop better in the controlled environment of an institution, where they are in the charge of adults trained in understanding their psychopathology and where they can attend schools to learn some degree of the skills necessary for an independent existence. Ideally the institution should also supply therapists trained in the use of the technique of psychoanalysis and whatever modifications of this technique are necessary for treating psychotics. So far the Southard School at Topeka, Kansas, is the only institution that meets these requirements. Adequate environmental conditions—though not the adequate psychotherapy—are provided by the Emma Pendleton Home at Butler Hospital, Providence; the Children's Department at Bellevue Hospital, New York; and children's departments of state institutions, such as the Children's Department at Allentown State Hospital. Schools for feeble-minded children also supply helpful environmental situations. Even with the most ideal setup and therapy, however, it is questionable whether such a child as the one in Case 44 can ever live an independent existence. Bender states that the therapeutic approach is directed essentially at the anxiety and secondary symptom formation, with help in integrating the behavior patterns and in promoting identification processes. Perhaps the best plan would be to have a psychoanalytically trained therapist treat the child intensively for a year or two until his ability to make a more useful object relationship has been increased, whereupon the number of interviews should be reduced. The reduction should be gradual, because these patients are extremely sensitive. They feel a slight deprivation as a major catastrophe and tend to respond to deprivations by a marked increase in all their defense mechanisms, i.e., in their basic symptoms. While the reduction in the number of interviews is taking place, opportunities should be substituted to learn skills

from competent and understanding instructors with whom the child can carry over his increased ability to enter into object relationships. This period of treatment should continue through puberty and adolescence, the intensity of psychotherapy varying with the psychic needs of the child during this stress-filled time. Toward the end of adolescence the patient should have several years of psychoanalysis.

Certain authorities like Bender use shock therapy as part of the treatment for childhood schizophrenia. With this I do not agree. I believe no kind of shock therapy should be used with children. At best it is not particularly helpful in schizophrenia and is distinctly inadvisable in persons under eighteen. If the child is completely unmanageable and if all other therapeutic methods have been tried adequately and have failed, in order to make the management of the child in the hospital easier the physician might consider using frontal lobectomy.

Even with the methods of treatment I have mentioned, the prognosis is poor. Bender states that "children whose illness begins before five and who show severe interference or regression in fundamental habit patterns, language, object relationships, motility and an absence of anxiety are not inclined to show remissions nor do they respond to shock treatment. Children in whom the onset may be just as early but who show an accelerated type of response with a great deal of anxiety and very severe symptomatic disturbances often respond to shock and psychotherapy. This treatment results in prolonged remissions in the disease which continue after they return to their homes and schools. The remission may last through the stresses of the pubertal period. Such children continue to seem relatively well, although they remain dependent on their families. However, clinical examination shows that they still have signs of schizophrenia." She believes that the prognosis for infantile schizophrenia is as good as for adults. One-third to one-half will make a fair to good social remission, but will remain vulnerable.

It need hardly be said that schizophrenia cannot be treated by the general practitioner, the pediatrician, or the neurologist. The interested reader will find an excellent review of the literature on psychoses in children in Little's¹² report.

¹² Harry A. Little: "Psychosis in Children," *Pennsylvania Medical Journal*, 51:2, November, 1947.

CHAPTER THIRTEEN

CHARACTER NEUROSES IN CHILDREN

SOME CHILDREN develop symptoms as a means of solving the conflict between their instinctual desires, conscious or unconscious, and their parents' training or its incorporation, their superego; these symptoms distress them. Others solve their conflicts by changing their character. These character changes, although they may cause suffering to other people and may limit the individual's chances of success, usually are accepted by him as a way of life, and he feels no suffering until perhaps the harsh realities of life make him realize that he is not adapting himself as well as other people do. The solution of intrapsychic conflicts by character changes is known as character neurosis.

AN INEFFECTUAL CHARACTER

CASE 45. A fourteen-year-old boy is referred because he is in danger of failing in his schoolwork; he is not getting passing grades in Latin, mathematics, English, and history, the failures being not in his examinations but the result of poor daily class work. He never gets his assignments in on time; his notebooks are never completed or even up to date; his homework is never done. In programs under the Dalton plan, he is always behind. When his teachers criticize him, he becomes repentant and promises to do better, but he never does. Usually he has innumerable excuses for not having completed an assignment. If the

teachers continue to "nag" him about his work, he becomes angry and feels they are picking on him unreasonably. He regards his parents' inquiry about his schoolwork as unjustifiable nagging (which it often is). He procrastinates endlessly before tackling his homework: he has to read the newspaper or listen to the radio, he has forgotten his assignment, has to talk to someone on the phone, does not have the proper books, etc., etc. When eventually he settles down to work the hour is so late that he is unable to complete his task. Thus each school evening consists of a long series of arguments between himself and his parents, particularly his mother, over the question of homework, the arguments usually ending in anger on both sides. Once, although he was in such great jeopardy in school, he missed a final examination, which he would have passed, because he was tired and overslept. He procrastinates, too, over household chores, with the same results. Though there is no reason for him to have to do household chores, the family having several servants, the parents felt he should learn some sense of responsibility by having such work assigned to him. He is interested in music and formerly played in the school orchestra. He does not like the instrument he plays and wants to play something else. His ambition is to lead a jazz band. He procrastinates over his practicing, as about everything else. He was often late for rehearsals and so lost his place in the orchestra. His attitude toward music is typical of his whole attitude toward life. As soon as he lost his position in the orchestra, he proceeded to neglect his schoolwork, often absenting himself from class in order to practice. Therefore he was forbidden to go to the auditorium, whereupon he went there more than ever. His school difficulty started with his entrance to junior high school.

He was tall and rather heavily built, and when he tried out for the football team the coach was delighted and accepted him as a member of the squad in training; at this point he began to lose interest, although he had plagued his father to buy him a pair of expensive football shoes. After a while the coach dropped him from the squad.

He was very interested in automobiles and spent considerable time studying and examining gas engines. He was not old enough to have a driving license but had learned to drive on his summer vacation. He wanted to drive in the city after his return but was forbidden to by his parents. One night when he and his sister were alone in the house, he drove her to one of her engagements, repeating the offense in spite of the scolding he received. He never took the car out for his own personal pleasure but always to be thoughtful of someone else.

As far as the parents knew, there had been no other major delinquencies, but they were worried lest he get into sexual trouble, having found a package of condoms in his room. He had a younger sister, aged twelve, whom he teased a great deal but of whom he seemed very fond, showing much physical attention and kissing her frequently.

He had difficulty in adjusting to new situations. He spent four summers at camp and had difficulty adjusting to his campmates. Once, in a violent fit of anger, he threw a glass at another boy. Also, only with great difficulty did he learn to swim.

He seemed ambitious and enterprising, wanting very much to earn money; yet when on his own initiative he arranged to get gainful employment, he did not work efficiently.

History. His parents had been married six years before he was conceived. His conception was planned. He was a full-term child. The labor lasted thirteen and a half hours and the delivery was instrumental. He was breast-fed for two months but had to be weaned because his mother developed an abscessed breast. He showed no reaction to the weaning. During his first five months, his mother employed a nurse to look after him. Toward the end of his first year he developed the habit of getting on his hands and knees and bumping his head against the crib or wall. When he was two and a half he was taken to a psychiatrist, who advised padding the crib. He was clean and dry both during the day and at night by the time he was two years old.

He had many colds during his first eight years. At the age of two months he had a severe attack of otitis media and continued to have attacks for several years. Between two and eight years, he had a severe attack of measles and a very severe attack of pertussis. When he started to speak he had a slight speech defect. He had always been a poor eater. He had a few mild temper tantrums. When he was two years old his sister was born. He did not show much overt jealousy, perhaps because he was promoted to an adult bed while she took his crib.

He started nursery school at the age of three. At twelve he was treated for his present problem for three months by a psychiatrist, without improvement. As far back as he could remember clearly—i.e., from six to eleven years—he suffered excruciatingly from nightly phobias. He had great difficulty falling asleep because he feared lest skeletons, ghosts, and witches come up the stairs into his room. He never told anyone about these fears but would call to his parents and ask them questions, etc., in order to have someone to talk to and calm his fears. During this period there was no complaint about his schoolwork. At the age of

eleven he decided the phobias were too upsetting to him and resolved never to think of them or be frightened by them again. Thereupon they ceased, and a short time later his school difficulties began.

His father was a successful businessman, extremely social-minded and active in social-reform movements. He was very lenient with his son. His work caused him to be absent from the home for two or three consecutive days every two or three weeks.

His mother was rather tense and fussy. She was overanxious, particularly when her son was ill. She was inconsistent, nagging him about his nonconforming behavior and at the same time asking him to drive her on an errand when she knew it was illegal and got angry when he took the car by himself. She suffered from severe migraine.

The paternal grandmother was very indulgent.

Examinations. The patient's physical condition was excellent. His I.Q. was 120. He was a very tall, rather narrow-faced boy who seemed to be quite easy and comfortable. He gave the impression of having little real initiative. The interview was mostly question and answer. He said he had been told he had an appointment. He described his school-work, saying that the change of high schools had thrown him off but that he was improving. He had failed in Latin, which did not matter because he would be taking Spanish instead next year. He thought he would go to college and then enter his father's business, which his father was building up for him. He did not like the first junior high school because the classes were too large. He did not like his present school for the same reason. He had no complaint about his teachers. His difficulty lay in the fact that he was lazy, talked too much in classes, and was inattentive. He got on well with his sister. His mother was very proud of him and he felt he was treated very well at home. When his time for induction in the Armed Services came, he would have to apply to either the Marines or the Army because the Navy would reject him on account of his ear defect. He did not want to go to camp because he preferred to have a job. Next summer he would go to summer school to make up the credits in Spanish which he would need to overcome his failure in Latin. He knew no reason for the episode with the car.

He showed real feeling when he spoke of his height. He said he liked athletics, although he did not take much part in them. He had decided to abstain from football on the advice of a twenty-six-year-old friend, who had told him that it was unwise for him to learn to play football because the exertion might damage his heart permanently and because he might have fractures which might damage his bones perma-

nently. He played baseball, but this was really half-ball; i.e., a baseball game played with half a rubber ball batted by the hand. Toward the end of the interview, he played with his cigarette case but did not smoke.

Subsequent interviews produced further important data. His mother had told him that when his sister was little he had been mean to her, dumped sand on her, and injured her by knocking her off her bicycle, as a result of which she got a permanent scar. He fought with her a great deal until two years ago. His mother treated the two children equally well. He and his sister often slept in the same room when the family had visitors; he both liked and disliked this arrangement. He felt he was attached to his father because his sister was attached to his mother. His mother nagged a great deal—at least his father said she did. However, he did not feel hostility toward her because of her nagging or toward his father because he scolded him for his poor school marks. He did many things that caused other people trouble—like taking his mother's driving license accidentally or taking her car and having a minor accident. He reported a number of incidents of having so openly disobeyed a prohibition as to court punishment. He complained about the unfairness of his teachers. His ambition was to be a band leader but he knew his father's feelings would be hurt if he became one.

It was evident from what he said that some of his bad school record was due to his desire to be kicked out of school so that he might become a band leader and yet not hurt his father's feelings by refusing to enter his business.

Diagnosis. His behavior showed many peculiar characteristics. In spite of his good I.Q. he was failing in school. He failed not because he could not do the work but because he would not do it. Even when he was getting a passing grade, he went out of his way to miss the exams, would not finish his work, or, if he did finish it, would not hand it in. In class he was inattentive and tried to distract the attention of other pupils from their work. Often he was late; sometimes he cut classes. His parents and teachers complained that he was irresponsible and, as often happens, tried to help him become responsible by taking the responsibility for his work from him by nagging, instructing, lecturing, and scolding. Their behavior served only to irritate him slightly and did not result in increased diligence.

He showed the same character traits in his orchestra work, in his athletics, and in his odd jobs. When asked the reason for his behavior, he offered many excuses which to him seemed quite valid. However, on

being pinned down, he admitted that his laziness and irresponsibility were the real cause. With this explanation, he rested content, not seeming to feel shame for being lazy and irresponsible.

He felt irritation at the nagging, lecturing, and scolding of the adults, but the irritation was slight and he tended to shrug it off and forget about it. As a result he really felt no anger or hostility toward them. On close observation, however, the hostile reactions were evident. His mother nagged him: shortly after, he accidentally went off with her driving license, which caused her considerable inconvenience—a retaliatory act, though he was unaware that he was retaliating. It angered his mother. She scolded him. He accepted the scolding as his just due for his carelessness. So he was punished for his hostility toward her, though unaware that he had deliberately brought the punishment on himself. When he wanted to do something he knew his parents would disapprove of, he did it in such a way that they would have to learn of it and hence scold him.

This behavior indicates the presence of two psychological mechanisms. He had a need to get caught and punished. He was unaware that he had this need to be punished and also was unaware that the punishment gratified some inner desire. (Both his parents and teachers, of course, were amazed and felt completely impotent when the usual function of punishment—i.e., as an incentive to change behavior—failed entirely with him.) He did not feel angry or hostile when he was badly treated, but he retaliated, always accidentally. He was unaware that his retaliatory action had the motive of revenge. He was unconscious of any hostile feelings against his teachers or parents and early in treatment flatly denied that any such feelings existed, a denial made in the face of the stories he told about his mother's actions toward him and in the face of his father's statement that his mother nagged him excessively. He was unconscious of his marked feelings of guilt, which he assuaged by getting himself punished by his environment and by his lack of success in his life.

His peculiar behavior was not the result of laziness or of irresponsibility but was an expression of his fear of doing and of having done wrong, i.e., of a sense of guilt. His sense of guilt centered in any hostile thought or action, as illustrated by the episode where he discussed the conflict between his respect for his father and his ambition to be a band leader. He did not dare to differ openly with his father about the plans for his future life. Instead, he tried to get the school to expel him,

whereupon he would not be able to carry on his father's business and so would be forced by circumstances (not by his own wish) to be a band leader.

This patient, who gave the impression of lacking both initiative and ambition, had really very strong initiative and ambition, but both of these traits were used for the purpose of failing. These character traits and his behavior accomplished several purposes. First, they brought him punishment which assuaged the intolerable feeling of guilt from which he suffered unconsciously. Second, they expressed his unconscious hostile feelings toward his teachers and more importantly toward his parents. Third, they served to repudiate any desire to be successful or independent, which two qualities, to him, represented the expression of hostility toward his parents and hence would cause him to feel guilty. Fourth, they enabled him to gratify his masochistic desire for his father's love—without, at the same time, any need to feel that he was being unmanly in so doing—and to gratify his desire to be the center of interest to his mother—again at the same time without the need to feel hostile toward his father. If he was so incapable as he seemed to be, who could blame him if he needed to be dependent on his parents and have them do everything for him?

His behavior was an attempt to solve a series of conflicts. There was the conflict between his hostility toward the father and his fear of retaliation for the hostility. (The fear of retaliation was a fear of castration: his associations were constantly about accidents, death, and injury.) Another conflict was between his love for the mother and his fear of the father's retaliation. Still another lay between his sadistic feelings toward his mother—i.e., his desire to be revenged on her—and his need for her love and affection, which he felt as a masochistic need. Finally there was conflict between his desire to be independent and his very strong desire to be dependent. He solved these conflicts not by converting them into physical symptoms, or by projecting them as phobias, or by dealing with them by obsessional rituals, but by traits of character.

He dealt similarly with his psychic conflict in his relationship with his sister. Early in life he was very hostile toward her and once inflicted an injury that left a permanent scar. Now he acted as if he were very fond of her—so fond that he went out of his way and broke prohibitions in order to help her. However, he could not participate in athletics lest he receive a permanent injury; i.e., he feared retaliation for his earlier hatred of her, among other things. In addition, his accentuated fond-

ness for her had a strong sexual tinge, and here again resulted in the conflict: "If I feel sexual desires toward my sister—or any girl—I have to get myself punished for having them." That he had not always solved these conflicts by deformation of character, however, is evidenced by the fact that between the ages of six and eleven he projected them in the form of phobias that brought tremendous conscious suffering. Only as he was able to remove the suffering by suppressing his tendency toward phobia formation did the disordered reactions in his character appear. I would classify him as a character neurosis.

THE PSYCHODYNAMICS OF CHARACTER

I have used the term "character" often in this discussion. What is character and what is a character neurosis? As I use the term "character," it may be defined as follows: Each individual has reaction patterns of behavior, particularly in the sphere of morals, that are specific for him, and if one knows the individual well, one can predict fairly accurately the way he will behave in a specific situation. The sum of these characteristic reaction patterns are his character, the patterns being compromise formations. Since all human reactions contain instinctual impulses as their basic driving force, such impulses are the driving force in character. Since the reaction patterns that form character are often concerned with moral values, the patterns that form the character contain a large element of superego and ego-ideal content. If a person does something out of or against his character, he feels ashamed or guilty, or fears conventional disapproval. If he does something according to his character, he feels satisfied, comfortable, happy, and elated. Since these are reactions that arise from superego praise or blame, they indicate the important role played by the superego in the reaction patterns that are called the character. Character reaction patterns are the ego's attempt to synthesize instinctual drives and superego control. The traits of the character are in the nature of sublimations (the process by which instinctual gratification is obtained through the inhibition of the aim of the impulse) or of reaction formations (the process by which the gratification of an instinctual impulse is obtained by accentuating its opposite). Any instinctual impulse may undergo this type of vicissitude. For example, sadism is partly an expression of the possessive instinct and can be sublimated and raised to the intellectual sphere as a desire to possess knowledge. Thus the instinctual drive obtains gratification but the gratification serves a useful purpose to the ego. The sadism may be

replaced by its opposite—masochism—when a reaction formation occurs. If the sadism has been partly sublimated into a desire for knowledge and then the reaction formation occurs, the desire for knowledge will be changed into its opposite—a desire not to have knowledge. Thus, too, in this indirect way, the sadism will be gratified and will serve a useful purpose in protecting the ego from the punishment of the superego—but the purpose will not be useful in reality.

Although the character traits have somewhat the same dynamic structure as a neurotic symptom—i.e., a compromise between superego prohibition and instinctual drives into which the patient has no insight—they differ in that the compromises that make the character are accepted by the ego. The repressed impulses have not returned as they have in the neurotic symptom but obtain gratification through reaction formations and sublimations. Since reaction formations and sublimations are not firmly fixed until there is almost complete superego and ego-ideal formation, the process of character formation is not completed until after puberty. Therefore, character traits are more apparent and definite after that time than before, although they have been present in various degrees of definiteness and solidity for a number of years—at least from as early as the beginning of the latency period. In my discussion of Case 36 in Chapter IX, I pointed out that it would be possible to prophesy the patient's character at the age of twenty-one by her character traits at the present age of six. Character traits or the automatic reactions of the ego are valuable when serving realistic purposes, since they furnish a more economical method of reacting than if each conflict has always to be handled in a new way.

THE PSYCHODYNAMICS OF A NEUROTIC CHARACTER

What is a neurotic character? Alexander¹ was the first psychoanalyst to make a detailed study of the clinical picture and structure of character neurosis. In the case under discussion, the patient's character traits do not seem to serve a useful purpose to the ego. Something has failed in the sublimating process. The sadism has been sublimated into a desire for knowledge, but this desire is regarded by the ego, under the influence of the superego, as an undesirable drive, the superego being sensitized prohibitively to the presence of the sadism even in its sublimated form, and the ego unable to utilize the desire for knowledge

¹ Franz Alexander: "Der neurotische Charakter. Seine Stellung in der Psychopathologie und in der Literatur," *Internat. Ztschr. f. Psychoanal.*, 14:26-44, 1928.

because of fear of punishment from the superego for the sadism inherent in the desire. Now as a negative expression of the desire for knowledge, the sadism can find gratification. It can find further gratification for its unsublimated component in the form of hurting the parents by the apparent lack of interest in obtaining knowledge. Therefore, there is a reaction formation against the sadism in the desire for knowledge, the reaction formation coming to constitute a character trait. Such a character trait does offer the ego some relief from punishment by the superego, but it constricts its capacity in relation to the environment. The superego is tricked, so to speak, by the presence of an apparent sublimation into allowing more direct gratification to the sadistic impulse, just as in the sublimation of sadism into a desire for knowledge, the instinctual drive is acted out in an uninhibited way and so does not appear as a perversion or a neurotic symptom. On the other hand, the partial sublimations and reaction formations that form our patient's character are acted out instead of appearing as perversions or symptoms.

Character neuroses may be classified into two types: (1) those in which the ego imposes great restrictions—usually in the nature of reaction formations—on the instinctual drives in order to appease the severe superego; (2) those in which the ego, to its disadvantage, imposes only minor restrictions on the instinctual drives, the conflicts appearing in the relationship between the individual and his environment. The status of the superego in this second group is variable and will be discussed later.

Psychoanalytic researches have established that character traits are the result of the methods used in dealing with the instinctual drives belonging to the pregenital stages of development; i.e., the two oral, the two anal, the urethral, and the phallic. For example, a child may cling tenaciously to the oral stage because of constitutional peculiarities or because he has been severely frustrated during it. This will result in a larger amount of libidinal energy remaining fixated at the oral level and in the child's having to deal with the fixated energy by reaction formations or sublimations. Thus he will develop a preponderance of oral character traits. And so on for the anal-sadistic, urethral, and phallic periods. The more severe the fixations at any one stage, the more fixed will be the character traits, and the more likely it will be that reaction formations will be the dynamic principle used instead of sublimations. The individual will probably develop a neurotic type of character whose purpose is not to place the energy at the disposal of the ego but to erect defenses against his pregenital desires in order to avoid the punishment

of the superego. Such characters differ from normal characters in that instinctual impulses do not obtain as much useful gratification. The ego is more constricted by its dread of the superego. The main mechanism is reaction formation plus the use of additional defense mechanisms that were appropriate at the stage where the main fixation occurred. This is true, also, of the more normal character types. Both the normal and the ego-constricted neurotic characters can be classified on the basis of their preponderant defense mechanisms into hysterical, obsessional, and schizoid character types. Among normal character types, the hysterical character is the most desirable. It is not necessary to discuss these character types further, since they have been discussed in previous chapters. Also I have reported in full elsewhere the case of a child with a beginning character disturbance.²

Psychopathology. The patient in Case 45 has character traits that are a reaction formation against his hostilities toward the father and sister and against his desire to be revenged on his mother because of his feeling that she does not love him. The guilt engendered by these repressed hostilities is also repressed but appears as an acted-out need for punishment. His use of reaction formation as defense indicates that he has regressed from the phallic level of development to an anal-sadistic one—at which period all aggressions are expressed as sadistic and masochistic drives. Earlier in life—i.e., between the ages of six and eleven—he dealt with these unsolved conflicts not by regression but by projection and phobia formation; when he deliberately stopped these methods of defense, he was left only with the possibility of regression, whereupon the mechanisms of reaction formation and partial sublimation were called into play and his character became deformed. Instead of the development of a neurosis through the return of the repressed, he began to act out his conflicts in his daily life. He had two basic traumatic situations—the birth of his sister, which caused him to feel rejected, and his long period of physical illness, which caused him to receive a great deal of extra attention from his parents. When this extra attention ceased as he became well, he became angry and hostile toward them, and began to project his jealousies, envies, and desire for revenge as phobias. When he attempted to cure his phobias, no real cure took place, but his character began to change.

Treatment. Therapy for such cases is exceedingly difficult. Neither ordinary environmental therapy nor ordinary psychotherapy is of any

²O. S. English and Gerald H. J. Pearson: *The Emotional Problems of Living*, London, George Allen & Unwin, p. 172.

avail. The one treatment that offers any hope of improvement is analytic psychotherapy, usually a classical psychoanalysis, during which each character trait is analyzed in terms of the original conflict which has remained unsolved. When the conflicts are made conscious, the ego can find sublimations rather than reaction formations for the instinctual drives, and character traits that result from the sublimations become of use to the ego in dealing with the environment. The period of therapy is usually quite long, but if successful, it is of great value.

It would have been well if the boy had been able to report his severe phobias at the time, if he and his parents had been able to realize his need for therapy, for some of the difficulties in therapy would thus have been avoided. The analysis of adults with a character neurosis has revealed that in childhood they suffered from severe phobias that seemed to cure themselves, the "cure" consisting in the relief of the discomfort of the phobia by a deformation of character.

There are certain aspects of our patient's character neurosis that cannot be discussed until we have considered the type of character neurosis in which the conflict is externalized so that it appears to be a conflict between the child and his environment. Before entering upon a discussion of these cases, however, it is important to discuss one that stands halfway between two types of character neurosis: (1) the type whose psychopathology consists of compromises by reaction formations and partial sublimations between the superego and the instinctual drives, and (2) the type where the conflict is externalized into one that appears to be between the individual and his environment.

TEMPER TANTRUMS

CASE 46. An eleven-year-old boy is referred because he has frequent and severe temper tantrums. If frustrated in any way, he screams, cries, and stamps his feet, then throws himself on the floor, thrashing around with his feet and hands and banging his head on the floor or against the wall. During this part of the paroxysm he swears and accuses his parents of wanting everything for themselves and of wanting to deny him everything. As the paroxysm becomes more severe, his thrashing, yelling, and crying cease momentarily and his eyes become fixed in a glassy stare. After a varying length of time—from several minutes to a few hours—he quiets down gradually and eventually gets up from the floor very fatigued and very remorseful for the way he has behaved.

These spells have occurred since the birth of his sister, although he

had a somewhat similar one the summer before she was born, at which time the family were visiting the maternal grandmother. The day they were to leave, the patient was left with his grandparents while the other members of the family went with the parents to get gas for the car. The patient wanted to go with them but was refused. While they were gone he hit his grandmother with great force across the knuckles. During the past year they have occurred about two or three times a month. Lately most of them have occurred in school. When the teacher asks him to do something, he gets up, throws papers around, and has a spell. During the last attack, the principal had to use all his strength to remove the patient from the room.

History. The family consisted of father, mother, a brother of fifteen, a sister of thirteen, and a younger sister. The parents were very religious, the mother, who seemed to be a mild person, carrying a Bible and a missionary book with her. She began the first interview by saying that she and her husband were willing to do anything to cure the patient's temper tantrums. She was anxious to terminate the interview to help with a church supper, having, in fact, hesitated to come for the interview because of the supper. She could not understand why a child brought up in a sensible Christian home should have such problems. Religion was emphasized in the home, and the patient looked forward to Sunday school and to the two church services. When the spells of temper became thus frequent she discussed the problem with the school principal. About a year before, she took the patient for psychiatric treatment, terminating it because she required an operation. The psychiatrist reported that after seeing the boy only five times, treatment was broken off by a letter from the mother stating that she was ill and under a physician's care. The interruption came when the patient was beginning to feel a little less fearful of the psychiatrist and was starting to work in treatment. After the mother became well she saw no necessity for further psychiatric treatment because she had great faith in the patient's New Year's resolution not to have any more temper tantrums, and she felt that remedial teaching and careful handling in the home would solve the problem.

The patient was a full-term baby and was weaned to a bottle after three weeks of breast-feeding. At four years he fell and had a mild concussion. His nose was broken three times within a year. He was lovable before six years of age, when the spells started. He had never shown any malice about punishment. He had willingly gone to the basement for a spanking and was friendly with his father immediately after the

whipping. During the past year the patient was closer to his father. When the sister was born, the parents saw that he got as much affection as did the baby. He had always been affectionate and co-operative with her. His brother bossed him and teased him about his spells, and both boys were always at cross-purposes. At school, too, he was teased about his spells. Both patient and mother disdained their neighborhood because it was Catholic; the first thing the patient said during his interview was that he was glad this was not a Catholic hospital.

Examinations. His physical examination revealed no abnormal conditions.

Psychological examination showed that he had good intelligence but needed remedial instruction in arithmetic.

During the psychiatric interview the boy was most co-operative, friendly, and spontaneous. (It was evident that the rapport was always superficial.) He said he was most anxious to get well and did not like to have "spells," which he refused to describe. He was interested mostly in talking about church affairs, his baby sister, and his inability to do arithmetic. He said he was left back in 4-B because of his stubbornness over arithmetic. He made one very significant statement. He would rather stay at the hospital, because the doctors gave him attention and he liked everybody there. He could not decide whether he wanted to go home or not. He flatly refused to discuss these feelings further.

Diagnosis. The diagnosis of his condition would be a character neurosis. Though his attacks closely resembled epilepsy, except that there was no real loss of consciousness, they were really temper tantrums—more severe than usual. In the ordinary tantrum the child becomes angry, kicks, screams, stamps, hits, bites, holds his breath, stiffens his body, throws himself onto the floor, and struggles against all attempts to control him. During this period he is deaf to reason, persuasion, command, or punishment and inaccessible to all external influences.

Psychopathology. In order to attempt to understand the psychodynamics of this child's temper tantrums, we have to consider first the description of the attack. The child becomes angry and behaves as I described earlier, or his pupils dilate, he stands immobile and rigid for ten or fifteen minutes, cursing or talking against the church, after which he collapses completely, throwing himself into a chair and sobbing violently for a long time, perhaps two hours, and threatening to kill himself. Throughout the attack it is impossible to reason with him. He has two types of tantrums, one during which there is great motor immobility and one in which there is great motor activity.

When an individual is exposed to an external danger, the ego becomes aware of the unpleasant feeling of fear and anticipation of pain. In order to remove these unpleasant feelings, the ego as part of its executive function mobilizes aggressive energy, using the motor system as the vehicle for its expression and directing the mobilized aggressive energy into the muscular system to remove the danger. This direction has two phases. There is a state of rigid expectancy, wherein all the musculature is equally innervated in preparation for whatever action may be necessary. Then the individual either attacks or flees through the innervation of the appropriate muscular system. A similar reaction occurs when the individual is frustrated. There is first a feeling of disappointment. The mobilized aggression is accompanied by a greater or lesser feeling of anger. The ego directs this aggression into the innervation of the musculature that will serve as the appropriate vehicle to inaugurate some new action that will overcome the frustration or some action that will eliminate the cause of the frustration.

In the usual reaction to a danger or frustration, the first phase of motor innervation is brief and the second consists of an attack against the frustrating object. In this boy's tantrum the first phase is prolonged and the second phase consists of verbal activity and in his throwing himself on the floor. (This pattern approximates more closely the epileptic reaction than it does the reaction to danger or frustration. In the epileptic, too, frustration causes the aggression to be mobilized, but the first phase—that of rigid expectancy—is the most prominent, the second phase appearing in the convulsion.)

In the normal person a frustration produces a painful feeling of disappointment which sets in action a motor pattern. If the motor reaction is delayed, there is a feeling of anger. Between the time of frustration and the feeling of disappointment there occurs a momentary turning away of the ego from the external world. When the frustration is severe, the normal person is often conscious of this desire to give up everything. When the frustration is slight, the person may not be aware of this pattern of withdrawal because it takes place in the unconscious. It is the customary reaction of a small baby when confronted by an uncomfortable situation, as Levy³ has described. It is this turning away from reality that causes the conscious feeling of disappointment, whose purpose is to warn the person that such a withdrawal from reality is dangerous. The degree of the withdrawal from contact with reality forms

³ David M. Levy: "Resistant Behavior of Children," *American Journal of Psychiatry*, 4:503, 1925.

CHART I REACTION TO FRUSTRATION

REACTION TYPE	FEELINGS OF DEPRI- VATION	AGGRESSION MOBILIZED BY EXECUTIVE FUNCTION OF EGO	REASON FOR INAD- EQUATE REACTION	EFFECTIVE- NESS OF REACTION	END RESULT	
		STAGES OF IMMO- BILITY	PURPOSE- FUL MOTOR INNERVATION			
I Normal	yes—per- haps ac- companied by anger	brief	of motor sys- tem that will be adequate to attain a gratification similar to that of which the person was deprived	Results in at- taining of a new satis- faction.	satisfac- tion	
II Ordinary Temper Tantrum	yes—plus a great feeling of anger	brief	of motor system for attack on frustrator	frustrator is superego which can- not be di- rectly at- tacked or destroyed	The frustrating superego can- not be removed, so all the energy that might go toward obtain- ing a new satis- faction is dissi- pated in the struggle. If car- ried out, might remove frustra- tor but no en- ergy is left to attain a new satisfaction.	fatigue
III Patient's Tantrums	yes—plus a great feeling of anger	pro- longed	almost ab- sent except for verbal action	strong feel- ings of fear and guilt so that no at- tempted attack on superego is possible	Frustration continues.	extreme fatigue
IV Epilepsy	sometimes —some- times ac- companied by anger	pro- longed	absent	organic defect or psychic defect in executive function of ego	Frustration continues and ego withdraws from reality. To do this, un- consciousness is necessary.	loss of con- scious- ness

a series from the normal to the epileptic. In Case 46 it was reported that during the patient's spell no one could reason with him, though this is true for all temper tantrums, as we have seen. His period of withdrawal from full contact with reality is prolonged and the degree of withdrawal accentuated. The ego has for the time being reacted to a frustration by turning away from the external world, of which it has become temporarily partly unconscious. Though in the epileptic the withdrawal may not last as long as in the temper tantrum, its degree is much greater, the ego actually becoming unconscious of the external world. Thus the degree of withdrawal being greater in the case of our patient, he approximates more closely the epileptic reaction than the normal.

What happens during the withdrawal? A child's temper tantrums begin when he is told to do something he does not want to do, when he is denied a wish, when there is change in routine, or when he fails to manipulate successfully some physical object. He reacts to this external and often insignificant frustration by turning away from the external world. Then he begins to feel that he is in the grip of some force that he cannot alter or control, a force that will defeat all his wishes, rob him of all pleasures, restrict all his movements, and reduce him to complete helplessness. Since the struggle he puts up in the tantrum is out of proportion to any actual loss or denial, we must therefore recognize that his most primitive fantasies and anxieties are at work. He is really fighting fantasied parents who are very cruel and will deprive him of everything. Isaacs⁴ makes this clear in her paper. The ego, having turned away from external reality, is forced to turn to the unconscious. It begins to observe more clearly its constituents, of which it was not heretofore aware.

Our patient curses (against God) and talks against the church (against God). His enemies are the internalized images of his parents who will deprive him of all pleasures. He dare not make a motor attack against them, for if his verbalized expression provokes the tremendous feeling of guilt and remorse that it does, how much more would the motor expression provoke!

Here again the ordinary temper tantrum, this boy, and the epileptic form a series. The child with an ordinary temper tantrum reacts violently against the fantasied persecutors; this boy inhibits the violence

⁴ Susan Isaacs: "Temper Tantrums in Early Childhood and Their Relation to Internal Objects," *International Journal of Psychoanalysis*, 21:280, 1940.

of his reaction and is almost helpless in its power; the epileptic is completely helpless and becomes unconscious both of the external world and of his internal psychic world. We can see how perilously close this boy comes to being an epileptic.

The instinctual desires of the child in a temper tantrum have met a frustration, which cripples the reality-testing function of the ego. The degree of development of this function is in direct ratio to the freedom from fixations and repressions that occur early in life. If the development of the reality-testing function is slight, it is more readily relinquished in the face of a frustration, no longer serving to direct the expression of the instinctual energy. The latter becomes introverted, and the patient appears to withdraw from contact with the external world. This is a dangerous reaction and occurs in the psychoses, a history of temper tantrums in childhood being found more commonly in adult psychotics than in normal people. Its constant occurrence in temper tantrums (it should be emphasized that all children under six have occasional temper tantrums as a phase of their normal development) indicates that the child is using this means as a way of life.

The five reactions—epilepsy, this boy's tantrums, the usual temper tantrum, the reaction to frustration by attack on the frustrating object, and the reaction to frustration by undertaking an action that will relieve it—form a series of increasing usefulness, the epileptic reaction being the least useful, and that of action to get satisfaction the most useful. In the epileptic reaction the subject is overwhelmed by his own aggression; in the reaction of action to get satisfaction, the frustration is overwhelmed by the subject's aggression. The epileptic is unable to direct his aggression adequately because of some defect either of an organic nature or in the psychic representation of the organic body, as Kardiner⁵ has pointed out. In our patient, the executive function of the ego is defective because of his feelings of fear and guilt about the purpose of his wish to use his aggression motorially. These feelings are shown by his reaction to the tantrums—his remorseful sobbing and his desire to kill himself. (It is well known that a desire for suicide often is an expression of aggression toward an object which is redirected toward the subject because of guilt feelings.) In the ordinary temper tantrum, the child permits himself to act physically, but the destructive purpose in his actions becomes ineffective: he cannot remove his frus-

⁵ Abram Kardiner: "The Bioanalysis of the Epileptic Reaction," *Psychoanalytic Quarterly*, 1:375, 1932.

trations, for they are his own internalized bad objects—that is, his superego, which he has incorporated from his parents and to which he has added the energy from his strong desires in order to keep them and their expression within limits of which his parents will approve. The motor expression is directed against himself, but he can use it only partially—for example, by banging his head on the floor or by hitting himself. In brief, in the ordinary temper tantrum the child feels fearful about the strength of his desires. When he experiences a frustration he feels helpless lest he suffer more severe deprivations at the hands of his fantasied parents. I have tried to depict these reactions graphically in Chart I (see p. 271).

Our patient's tantrums are more severe than usual. He is a very sick boy, standing close to epilepsy on the one hand and to a psychosis on the other. He has two main intrapsychic problems: (1) he is unable to express his aggression because of his feelings of guilt; (2) he reacts to a frustration by withdrawal of his ego from the external world. What was the origin of these problems? According to the history, his temper attacks began about the time he started school, and also about the time when his sister was born, before which he had been the baby of the family. This might indicate that he had been spoiled; but considering the type of family, it seems more probable that he was brought up under severe restrictions and allowed to function only if he avoided expressing any aggressive or sexual feelings. In order to be a good boy, acceptable to his family, he had to repress such desires, and to accomplish such repression he had to erect an extremely cruel superego. He tried to avoid his jealousy—an aggressive reaction—by planning eagerly for the new baby and by being affectionate and co-operative with her after she was born. This mechanism did not work, however. He began to bring into play the mechanism of turning away from the world which was so frustrating to him. The most frustrating parent seems to have been the mother, as evidenced both by her personality and by his attempt to keep his desires repressed through an identification with her; he seems to feel that his father is more understanding.

Treatment. Treatment for this boy should consist of removal from his family and placement in a home of understanding and sensible adults. Or the mother should receive psychiatric treatment. In any case, the boy himself should have intensive psychiatric treatment. But none of these courses is possible. The mother regards the boy's tantrums as a sign of sinfulness and believes that if he wills it enough he can stop them. She feels that his promise not to have any more tantrums is the

real therapy needed. In reality, if the boy tries to stop the tantrums by sheer will power he must become either epileptic—i.e., make himself totally unconscious of his reactions—or withdraw from frustrating reality into a psychosis. At present he is dealing with his conflicts by an alteration of character.

CHAPTER FOURTEEN

CHARACTER NEUROSES IN CHILDREN (*Continued*)

AN ANTISOCIAL CHARACTER

CASE 47. A ten-year-old girl is referred because of her chronic aggressive behavior. She refuses to conform to the ordinary routines in school. When supposed to be working quietly she gets up, walks around the room, interferes with the other children, talks loudly, and interrupts the teacher. When the teacher rebukes her she talks loudly and rudely, calls her profane or obscene names, and runs out of the room and often out of the school. Once she brought a car from a toy train to school and hit the teachers and the children with it. She says she hates everyone in the room, especially the boys, but is frequently heard asking the girls, "Aren't I a friend of yours?" When the other children do or say something that displeases her, she attacks them violently, and often does so without provocation. She is especially brutal toward an albino child in the group, who is very shy and submissive because of her poor vision. She frequently bursts forth in angry discourses about her sister, relating with glee that the sister still wets the bed and making up wild stories about the toilet habits of playmates also. She expresses an inordinate concern and curiosity about sickness of any sort: whenever anyone is absent she urges the teacher to call his home and find out "what hurt him"; when a child is taken sick in school, she is always the first on the scene and recounts the gruesome details to everyone else or, if prevented from witnessing the scene, plies the teacher with questions. Her school

achievement suffers as a result, but less than might be expected, for she has good intellectual endowment.

She attacks, disturbs, and fights with children of both sexes of her own age; she destroys their productions; in particular she attacks, frightens, and harms smaller children, who in consequence have to be protected from her.

At home and in the community, her behavior is the same—defiant, disobedient, openly rude and profane to her mother or other adults, and antagonistic to her sister.

Her parents are Jewish; she is a Catholic and is openly and violently anti-Semitic. Her parents were staunch supporters of the late Franklin D. Roosevelt; she is a violently aggressive Republican. She was a staunch adherent of Hitler, the Nazis, and the Japanese, constantly heiling Hitler and wearing swastikas on her clothes.

Her behavior dates back to the time she entered school at the age of four. During her first year at school she refused to conform and constantly attempted to remove all her clothes. Her behavior was so impossible that the school refused to allow her to return for the second year, although they had no trouble with her twin sister. Both children were changed to another school, where the patient's unruly behavior continued, though to a lesser degree. The next year, when she entered first grade, her behavior became more difficult. She was negativistic and had many tantrums; she spent a great deal of the time sitting under a table; her undressing continued. During the summer vacation she and her sister went to a day camp, where she made a fair adjustment; i.e., in the more active life and lessened routine of the camp her behavior was not so conspicuous. On her return to school there was a continuance of the nonconforming, defiant behavior, and after a few months the school suspended her. She was entered in a private school, which suspended her after a few months. At this time she began to have frequent nocturnal anxiety attacks and was examined by a pediatrician, who found that she was in good physical health, although small and underdeveloped. She was then entered in another private school, which suspended her after a few months. Still another private school was tried, but her behavior was even more difficult; she fought with the teachers and other children, defied all routines, and ran out of the classroom and the school. However, they put up with her, and she was under the tuition of a particularly understanding teacher, in whose class she was for two years. The summer before she came for treatment she attended camp, but after five weeks the camp sent her home.

History. She was the elder of twin sisters and had a brother several years older. Her mother was well during the pregnancy, although undergoing some financial worry and disliking the city in which they lived. Her birth was normal. Both girls were breast-fed for four months, the mother alternately giving the breast to one child and the bottle to the other. At the time of their weaning the mother went away for a week because she could not stand seeing the children's unhappiness at being weaned. The patient suffered slightly from rickets. Her mother stated that there was no difficulty in toilet training, but the patient had memories of urinating under her sister's pillow and bed as a jealousy gesture and also related episodes of fecal play and smearing. She did not talk until she was three years old, at which age the mother arranged for a short period of psychiatric treatment with a competent child psychiatrist, but interrupted treatment because she felt no progress was being made. Up to the age of five, both children were looked after part of the time by a censorious English couple.

At the age of three the patient had mumps and a severe attack of whooping cough. Up to this time she had slept in the same room with her sister, but from then on they had separate rooms. The patient played with her sister and with no other children until she entered school.

The father was usually kind and gentle. The mother tended to be indulgent but was high strung. The brother was fond of her.¹

Examinations. Physically she was rather thin—and bitterly resented her thinness. Otherwise her health was excellent.

Her I.Q. was 130.

In the first eight treatment interviews, she behaved with me as she behaved elsewhere. She talked and walked like a gangster's moll, scribbled profanities and obscenities on the playroom walls, reported many episodes of nonconforming behavior, told dirty stories and rhymes, paraded her Nazophilic and Japanophilic sympathies, and stressed her interest in the Catholic religion and her anti-Semitism. She reported her stealing, her attempts to spy on the father and brother when they were nude, and her investigation of the father's unopened mail, and accused the mother and teacher of beating her. She also told the mother that I had beaten her and several times became furious with me and berated me profanely.

Diagnosis. The patient's outstanding characteristics were her verbally expressed hatred for every ideal of her parents and its demonstra-

¹ I have reported this case elsewhere. See Gerald H. J. Pearson: "The Psychic Effect of Pertussis," *The Nervous Child*, 5:316, 1946.

tion in situations where she knew she would invite painful retaliation. Though she knew that practically all of the children on the school bus were strong supporters of Roosevelt, she appeared on the bus shortly before election day wearing two huge Dewey buttons, whereupon she was promptly assaulted, became very angry, and refused to go to class. In school she secretly destroyed a boy's poster, but her offense was soon discovered and she got into trouble.

Unlike the patient in Case 45, who behaved in ways that were unfavorable to his own success and happiness, this patient's behavior caused discomfort to the environment. Later we will see that she suffered from a character neurosis.

DELINQUENCY IN CHILDREN

Let us first discuss the whole question of rebellious and annoying behavior in children. Antisocial behavior is usually referred to as delinquency, which is defined as a falling away or lapse from the standards of the group—standards that have become universally a part of the super-ego and so form the basis of our culture; or, more to the point, a form of behavior that expresses rebellion against the standards of the social group.

Rebellion is a form of expression of the aggressive instinct whose aim is to break down, destroy, and injure the environment. Its purpose is to change the environment, and in this way it has been a useful servant to man in his rise from primitive, uncivilized conditions to the civilization and culture which contribute so much to his personal comfort and to that of the group. Furthermore, if the rebellion is against social conditions that deny the rights of individuals, it can be an extremely progressive form of behavior—an attempt to make the reality principle conform to the more basic pleasure-pain one. However, rebellion does not always have this motive. In some instances, it may propose to change the environment so that the individual obtains more comfort—for example, by the invention and perfection of labor-saving devices, by the development of better housing, and by social reforms such as the overthrow of tyranny. It also may attempt to change the environment so that the individual will be permitted a greater degree of libidinal pleasure, as in social reforms of a permissive nature, such as the revocation of blue laws. However, it may also be used as a counter-revolutionary force to maintain the existence of the status quo. All such rebellious procedures are desirable and useful from the standpoint of the individual

as well as of the social group, provided they are expressed in an adequate manner at the proper time. As such they can be designated as revolutionary, although they seem to be entitled to this designation mostly in retrospect. If they are not expressed in an adequate manner at the proper time, they are designated as rebellion, even though this designation may be altered to one of revolution by the next generation.

Since rebellion is an expression of aggression which is an instinctual drive (designated by Freud² as the death instinct—Thanatos), a certain degree of rebellion is natural to human beings. But many of its manifestations are the result of frustration.³ If a baby is annoyed by someone, he will crawl to his mother for protection or otherwise remove himself from the source of annoyance. If a child of four is annoyed, he will react motorially—hitting, kicking, and biting. If he is older—i.e., about six—he will retaliate by name calling or swearing. The adolescent will react in either or both of the two last-mentioned ways but at the same time, if he has learned that such behavior brings punishment, will try to avoid getting caught. A mature adult will attempt to put up with the annoyance as long as possible, but when it reaches a certain limit, he will speak or act aggressively, being willing to take the consequences unless these are torture or death. Certain mature adults who are very idealistic may even be willing to take these consequences, provided they are certain that their actions will bring benefit to other people.

Rebellion, therefore, is a natural mode of expressing aggression that is most frequently called into action as the result of unpleasant, frustrating external experiences. It may also be called into action if the individual has not learned to accept and for the time being put up with a certain amount of frustration.

The naughty or delinquent child is a rebel against his parents, his teacher, or the social organization. In order to understand the reason for his rebellion—and this understanding is the professional duty of every physician who wants to be of help in the case—it is necessary to understand the environmental situation and the personality structure of the child. Basically the rebellious child is attempting to protect his integrity by attacking some danger either to his pleasure needs or to his need for stability—i.e., this need to continue to repeat former experiences. A living organism in a dangerous situation may use other

² Sigmund Freud: *Beyond the Pleasure Principle*, International Psychoanalytic Press, London, 1922.

³ O. S. English and Gerald H. J. Pearson: *The Emotional Problems of Living*, London, George Allen & Unwin, p. 128.

methods of protection than fight; it can flee from the situation, or it can so change itself as to be comfortable and safe while remaining in the situation. The rebellious child uses neither of these methods. He attacks instead. This means that he is essentially a courageous person. As far as can be ascertained, a part of his courage is his by constitutional endowment. (He probably was originally one of those babies who are innately active and aggressive.) This is an important point to remember, because no therapeutic measure is proper that will attempt to suppress this courageous reaction.

A CLASSIFICATION OF DELINQUENCY

As I mentioned before, in order to understand the rebellious child it is necessary to understand his environmental situation—past as well as present—and his personality structure. The study of a number of such cases leads me to attempt a classification, tentative and probably not including many important types.

Type 1: Rebellion against an unreasonable adult or social ideal as to what the behavior of a child of a certain age should be.

CASE 48. A boy of ten who has previously shown no rebellious behavior suddenly becomes a problem in the classroom. He lives in a foster home, having been orphaned a number of years before.

When the situation was investigated, it was found that the teacher had a peculiar prejudice about foster children: all children in foster homes were there because they had delinquent parents and therefore were themselves potential delinquents. The teacher's mission in life was, therefore, to save this child from further delinquency through training. The slightest deviation from absolute conformity had to be stopped immediately, although when another child—not a foster child—did exactly the same thing, he did not criticize or punish him. The patient began to feel that his teacher was picking on him because he did not like him and responded by hostility. This increased the teacher's zeal to make him reform and, in turn, the patient's feeling that his teacher did not like him and, therefore, his hostility. The problem was readily solved by transferring him to a teacher who was not prejudiced against foster children.

Similar unreasonable demands are often made by parents because they lack knowledge of what behavior is usual at a certain age. If their child has enough courage he will rebel, and his rebellion will show itself in bad behavior. His personality structure—i.e., the interplay be-

tween the forces of the id, ego, and superego—is normal and if he is placed in a more reasonable environment, if the adults stop making unreasonable demands, his rebellion ceases—that is, provided the conflict has not gone on too long, for the longer it continues, the more the child's pattern of rebellion becomes fixed and the more likely he is to feel that even reasonable restrictions are imposed for an unreasonable purpose and are therefore to be attacked. Eventually he may develop a real anti-social character pattern that will remain throughout his life. Thus we see a vicious cycle of the child's hostility, the environment's counterhostility, and the child's counterhostility.

Type 2: (a) Rebellion against unreasonable environmental frustrations of instinctual needs and their derivatives.

Case 49. A ten-year-old boy has started to steal. He has been receiving an allowance adequate for his age and social position. But it turns out that his parents demand that he allocate the allowance in certain fixed ways, after which he is left only five cents a week for spending money. Since this is not sufficient for his needs and since the parents refuse to change their demands, he has begun to supplement the allowance through stealing, hating to do so and feeling very remorseful after.

His personality structure is adequate, and his behavior is the only way to deal with an impossible situation.

(b) Rebellion against an environment that is excessively stimulating instinctual desires whose demand for gratification produces a serious intrapsychic conflict.

Case 50. A girl of fourteen began rather suddenly to stay away from home and out late at night. Her schoolwork was poor, and as it grew worse, she began to truant, spending most of her time with a young married couple whom the father blamed for her delinquent behavior, forbidding her to see them, but to no avail. Her father took her to the counseling service of the school system and then, when this did not result in better behavior, consulted the local police, arranging with them that if the girl were seen on the street after 8 P.M. she was to be picked up and brought home. The girl had complained of headaches to the counselor, who referred her to a medical clinic, which, finding that the headaches had no organic basis, referred her to the department of child psychiatry. After an intensive study of the case, particularly after the patient's confidence had been gained, she revealed that she stayed away from home because her father was making sexual advances toward her. He had already served a term for making advances toward little girls in the neighborhood in which they had formerly lived. The girl's story

was corroborated by the mother, who said she had known what was going on but had not been able to do anything to stop it. She had not wished to reveal it to anyone outside the family.

The girl's antisocial behavior was not, therefore, so much a rebellion as an attempt to flee from the conflict between the stimulation caused by the father's sexual advances and her dread of punishment from the superego if the incest taboo were broken. I might say in passing that such situations are the basis for the peculiar, apparently delinquent behavior of a certain number of adolescents. Unconscious attempts by parents to seduce sexually their children of the opposite sex, particularly in adolescence, is often the basis for the bitter quarreling and open rebellion on the part of the latter at even the most reasonable demands made by the former.

Type 3: Antisocial behavior because the child is being reared in an environment whose cultural pattern is different from that of the group.

I have discussed this type fully in another place,⁴ and it will suffice here simply to present a familiar situation. A child brought up among feuding mountaineers becomes accustomed to look on the feud as a natural part of his existence. His loyalties to his family's ideals are so strong that he will carry on the feud to the extent of killing members of the enemy clan without regarding the act as murder—as it is regarded by the law and by the more civilized parts of the community. The relations between the forces of his instincts, ego, and superego are adequate, and he shows both fear of and loyalty to his superego. The latter, however, is developed from his family's moral standards. These permit killing as a justifiable and even laudable act.

Type 4: Antisocial behavior because the child has inadequate intellectual development and therefore lacks foresight, judgment, and the ability to recognize cause and effect.

Feeble-minded children's antisocial acts are usually minor ones, except if they are terribly angered or used as a cat's-paw by more intelligent and therefore shrewder delinquents. I have already discussed the problem of feeble-mindedness in Chapter X. Their personality structure differs from that of the average child because the ego is defective and the superego may be also.

Type 5: Antisocial behavior as the result of cerebral insult.

CASE 51. A nine-year-old girl is such a behavior problem that she has had to be suspended from school. At times she would do everything she was told; at other times she would be stubborn and defiant, walking

⁴ English and Pearson, *op. cit.*

around in the classroom, chewing gum, and talking back to the teacher. She quarrels and fights with other children. She often swears. She wants her own way in everything and does not listen to any admonitions. When her parents want her to go to bed, she pays no attention to them; if forced to, she fights off sleep. She shows no respect for adults. If denied something, she has a temper tantrum. She is fond of food and often eats too much. When another child has an orange, for instance, she will take it from her without eating it. It seems impossible to stop her attacks on her sister. After a stubborn and defiant episode she will apologize, saying she does not know what makes her behave that way and that she wants to be good. She is good at figures and at checkers and likes to show off her ability in things she excels in. She likes music, drawing, and painting but does not do well in them because she does not have enough patience to learn the skills adequately. For a while she disliked reading but has recently shown more interest.

History. Her birth and early development were normal; she had measles at four and a half years, tonsillectomy and adenoidectomy at six. Shortly afterward she had epidemic encephalitis. As she slowly convalesced, her appearance changed and she began to have convulsions. She had two of them in school. Her behavior became unmanageable: she began to have temper tantrums; she became impatient and unable to concentrate; she quarreled, fought, was defiant and stubborn. She began to create embarrassing situations with her sister and her sister's friends. All forms of punishment were ineffective. She took up the time and energy of her parents and took advantage of their affection and indulgence.

Examinations. She was a well-built girl who looked older than her years, being four feet eight inches tall and weighing ninety-eight pounds. The mucous membranes of her nose were markedly inflamed and there was some discharge. Her left nasal passage was small. There was a slight fullness of the thyroid, and her inguinal glands were lightly enlarged on the right. Her teeth needed cleaning; they were widely spaced, and some were decayed. Her pulse rate was 102, her blood pressure 114/54, and the pulse pressure 60. She had infected ingrown toenails on her big toes. She complained of headache after her convulsions. In the past she had worn glasses. Her handgrip was rather poor on the right and her patellar reflex was more active on that side. Otherwise the physical examination was negative.

According to the school records, the patient was a normal girl of good mentality. In the Philadelphia Mental Ability Group Test which was

given before she had her attack of encephalitis she had an I.Q. of 120. After her illness the psychologist reported as follows: At the beginning of the psychological examination, the patient co-operated very well and seemed to be concentrating and trying to answer the questions to the best of her ability. She soon lost interest, however, and had to be reminded to try to answer. Several times she wanted to go to her mother and pretended to cry, but when no attention was paid to her request, she stopped the pretending and said she was only joking. She was a talkative child and would make no effort to answer the test question and would even claim not to know the answer, until after she had said what she wanted to, when she would suddenly remember the answer. By this behavior she achieved her wishes. She had a basal age of eight years and an upper limit of eleven years on the Stanford-Binet Intelligence Scale. She did rather well on the Rhyme, Arithmetic and Reasoning Tests but not so well on the Verbal and Picture Absurdities and the tests requiring memory ability, such as the Digit Repeating Test and the Design Test. Her chronological age being 8-8 and her mental age 8-8, she had an I.Q. of 100.

The psychiatrist reported that she was a well-developed girl who looked much older than her age. Although she appeared tired and sleepy, she roamed around the room somewhat restlessly. She had a postencephalitic facies. She was correctly oriented. She had no hallucinations. Her stream of thought was free and connected. Her memory for remote and recent events was good except for the periods during the convulsions and immediately after. She realized she had convulsions. She did not understand that her personality had changed. She reported that she thought she was picked upon occasionally.

Her Rorschach test showed that she had a lack of control with occasional impulsive behavior. There was also hostility and opposition. She showed a great need for affection. Complexity was distasteful to her; she was unable to comprehend any but simple tests. She showed great rigidity. She did not see things as other people did. There were indications of an organic pathology. Her emotional maturity and intelligence were both on a preschool age level.

The patient's rebellious behavior was the result, not of a need to rebel, but of her inability to control her aggressive impulses because of the damage to her brain caused by the encephalitis. This cerebral damage cannot be repaired. She can be helped to learn how to control her impulses by kind, firm, consistent educational methods which are best applied in a controlled environment, such as a hospital for behavior prob-

lems resulting from encephalitis and from cerebral injuries due to poisons, toxins, and trauma. The prognosis in at least half of such cases is not very good.

Type 6: Antisocial behavior due to a psychosis.

I have discussed this type fully in Chapter XII.

Type 7: Rebellious behavior in order to gratify a need for punishment.

It will be recalled that the patient in Case 45 (see p. 256) showed this mechanism, among others. He did certain things which he knew were forbidden and did them openly so that there would be no possibility that his act would escape detection. He would be caught and punished and would honestly express remorse for what he had done. Then for a brief period his behavior would improve, to be followed shortly by another such episode. Underlying his behavior was a strong feeling of guilt of which he was unaware. The unconscious guilt, however, tormented him, and in order to have the discomfort assuaged, he would get himself punished for some offense. He felt guilty because he had strong feelings of hostility toward his father, who was so good to him that he could not allow himself to admit, much less express, these hostile feelings.

He showed in a mild degree the behavior that results from a need for punishment. Other cases have this need as their main dynamics, and their life is spent in antisocial behavior whose purpose is to attract punishment in order to assuage their sense of guilt. The social organization, through its legal machinery of punishment for crime, furthers the continuance of their pattern because it does not recognize the dynamics involved. The child in whom this mechanism is highly developed grows into adult life as a delinquent who constantly repeats his delinquencies.

There is really only one curative treatment for such a case, and that is psychoanalysis. And if the case is severe, even psychoanalysis will fail unless the patient remains in a controlled environment throughout the greater part of the analysis. For usually there comes a time when the patient attempts to assuage his sense of guilt—stirred up by the analysis—in his old way—by committing a delinquent act for which he is caught; and usually his punishment is such, particularly if he is an adolescent, that he is removed from treatment by it.

Type 8: Antisocial behavior due to the frustration of erotic needs.

(a) The perversions: These are criminal acts, according to the mores of Western civilization. I have discussed them at length in Chapter XI.

(b) Delinquency as a neurotic symptom: Every neurosis consists of

a return of the repressed in the form of symptoms. This repressed psychic content consists of early—pre-oedipal—ways and means of obtaining instinctual gratification, which find direct overt expression in the perversions, though their expression appears in a concealed and distorted form in neurotic symptoms. Some of these repressed desires are acted out in a distorted form in antisocial behavior (*see* Case 45). Other examples are kleptomania, which is an acting out of an unconscious wish to steal a penis and therefore occurs only in women; arson, which expresses an interest in flames, explosives, and water and so demonstrates its basis in the anal and urethral stages of libidinal development; stealing, which in children is often an unconscious attempt to retrieve from the phallic mother those objects—breast, feces, and penis and the libidinal satisfactions gained from them—of which the child fears the mother may wish to deprive him.

The personality structure in these cases is that of the neurosis—an oversevere superego—with a correspondingly weak ego which permits the return of the infantile repressed desires.

Treatment will, of course, consist of an analysis of the neurosis.

(c) Antisocial behavior as a result of deprivation in the parent-child relationship:

(1) Antisocial behavior often begins as an attempt to take revenge on the world and fate because the parents' interest, attention, and often affection have become centered on the new baby. The desire for revenge may become and remain an outstanding character trait.

(2) Antisocial behavior as a character trait may arise when an individual identifies himself with social justice. Robin Hood is the classical example of this. Betrayed by his superior and deprived of his property and title, he developed feelings of hatred toward those in authority. Unable to get redress from or vengeance on his oppressors, he began to take revenge on all persons in authority—particularly robbing the rich and powerful and distributing the proceeds to the poor and oppressed. He became a heroic figure because he took the law—not only the law of the land but the laws of economics also—into his own hands. Many, perhaps all children, show this mechanism of identification with social justice to some degree. In some children it becomes an outstanding character trait, even to the degree of antisocial behavior.

In all these instances, the character trait is a sublimated form of jealousy, envy, and hostility. Sometimes the child is right to take the law into his own hands against the unreasonable betrayals of his family, in which case treatment has to be applied to the family situation. At other

times the betrayal is largely a fantasied one and the child needs treatment for his unjustified desires for revenge. In this case the treatment is difficult because the child feels virtuous about his behavior and can cite many reasons why it is only sensible to behave as he does. He has, so to speak, twisted his superego into being on the side of his instinctual impulses, and receives from it commendation instead of criticism and punishment.

(3) Of somewhat the same nature is antisocial behavior as a manifestation of a cultural ideal. In America the cultural ideal is to be independent, daring, and self-made. Thus young adolescents reared in this ideal—particularly if they come from economically marginal homes or from disrupted homes and their craving for dependence is therefore increased, or if they have associated with other delinquents—find a mechanized world with a structure of rigid subordination and an economic cycle that can force them into unemployment. They try to escape from their need to be dependent and from this unstable and frustrating environment into the ideal of daring and independence. Some may find this ideal in becoming a member of the armed forces. Others find it in a criminal career.

Treatment must be directed toward a lowering of the severe ego ideal and an acceptance as reasonable of their need for dependence.

(4) Antisocial behavior as the result of direct parental rejection or of rejection disguised as overprotection. I have discussed this fully in another place.⁵ However, there are some additional causative factors.

Some children cannot form object relationships because of the adverse attitudes of their parents. The mothers tend either to spoil and indulge them in an inconsistent, teasing way or to be restrictive and rejective. The fathers tend to be irritable or jealous of the children or to be weak and ineffectual. With the boys, the mother is inconsistent, indulgent, and overprotective and the father weak, ineffectual, or absent; with the girls, the mother is inconsistent and the father irritable.

There are several other conditions found in children with a chronic aggressive character pattern that may also contribute to their patterns. They may have suffered from many or serious illnesses and consequently feel unable to do things for themselves. This tendency is found more often in youngest or only children. Weak parents are unable to help their children to learn to control and direct their aggressive impulses. Thus the children feel no security in their relationship with their parents. A child feels insecure when he has been unable to find an adequate and

⁵ English and Pearson, *op. cit.*, p. 243.

secure object relationship, either because he feels his parents cannot help him to control the expression of his instinctual drives or because all attempts to make a secure object relationship have met with painful frustrations. Hence he is afraid to attempt to establish an object relationship with anyone lest that relationship cause him pain, and thus the erotic urges are withdrawn from objects and directed toward the self (giving a feeling of omnipotence) and the aggressive urges are mobilized toward all objects. Such a child acts as if he felt extremely independent. He uses his infantile feelings of omnipotence to prove that he is self-sufficient and bolsters the feeling with his aggressive impulses, which are expressed openly toward adults and toward people of his own age. Since he cannot form an object relationship, he is unable to place these aggressive impulses under the control of any socializing forces. In the case of the child who is sickly, the constant variation between the parents worrying about his physical development and their austere attempts at training make for him a similar insecurity problem. The child blames and hates the parents for the feeling of insecurity and has great anxiety lest the known relationship, insecure as it is, be replaced by an even less secure one, as might happen with the birth of a new child.

The essential psychopathology of this situation is as follows: The child has a weak superego or a tendency to form a weak superego because his identification must be with either a weak father or a helpless mother. His ego has not developed beyond the point of a sense of omnipotence. This is not regression but lack of development. Consequently, he has little appreciation of his real weakness in relation to the reality of the great power of other people and of social custom. He tends, therefore, to operate on the original pleasure-pain principle rather than to subordinate it to the principle of reality. That these children are able to bolster up their insecurity by a retention of the infantile feeling of omnipotence and by aggressive motor acts argues that they must obtain a certain security by their behavior, painful as its results may be.

This security is a false one and resembles that seen in the false security through which the manic is able to violate all legal and moral restraints. Anthonisien⁶ quotes Abraham as saying that manic attacks are precipitated by situational factors and can be explained by past traumatic situations. The patient endeavors to cope with the difficulty by overcoming the superego; i.e., by regressing to a time when he felt free to do as he wished. In the case he reports, there was intense anxiety about the

⁶ N. L. Anthonisien: "Aggression and Anxiety in the Determination and Nature of Manic Attacks, *Archives of Neurology and Psychiatry*, 38:31, July, 1937.

situation in which the patient found herself, and she endeavored through aggression to overcome the factor that caused the anxiety. Although the manic is expansive and self-confident (in his state of mind), he is also quite aggressive and irritable. Anthonisien thinks that if the traumatic situation is one in which the patient has a hope of overcoming his obstacles, his initiative may be aroused, although it is also accompanied by a feeling of apprehension about the outcome. The initiative when aroused appears as the manic behavior. The hopefulness that the obstacle may be overcome by the aggressive acts arises only in those cases where the patient has some feelings of security. Otherwise the possibility of overcoming the obstacles would not present itself to him. The manic resembles the child with the chronic aggressive pattern, the behavior of the two being very similar. The latter is valiantly using his aggression to make his life situation more comfortable because he has a real hope that he can overcome these obstacles. On what is that hope based? There are several sources for it: (1) The child's direction of his erotic feelings onto himself gives him a feeling of omnipotence which enables him to disregard reality. This fancied omnipotence is the basis for his ability to use his aggressive impulses in an antisocial manner. (2) Such children tend to show a high degree of courage. I believe that part of this courage comes from the feeling of omnipotence which we have just discussed but that part of it is a constitutional trait. They are the hyperactive babies we saw earlier. They are hyperactive in utero and after birth are persistent and active, and react muscularly to any frustration. Though the hyperactivity and courage are constitutional traits, they are here being used in an antisocial manner because of the way in which the child has been reared.

(5) Identification with the aggressor, as illustrated by Case 47, to which we will now return.

Psychopathology. Treatment showed that the child's protective behavior was her means of expressing in one symptom—her behavior toward others—her infantile need to be cared for; i.e., her regressive need for love and her anger if she felt she was neglected.

Her behavior can be classified into four patterns: (1) a definite need to obtain attention of an unpleasant type; i.e., a regression to the sado-masochistic stage of object love; (2) a marked use of oral mechanisms, particularly scatological speech, for this purpose; (3) a desire to impress a love object unfavorably in a jealousy situation; (4) an identification with the aggressor in her attitude toward the training of small children.

Each of these patterns was directed toward her need for the mother's love, of which she had felt deprived from birth. They started with her attack of whooping cough¹⁰ which she and her twin had at the same time, the paroxysms being less violent in the sister. During this period the household duties and much of the care of the children were performed by the English servants. The mother stated that they were extremely irritable with the children and particularly disgusted by the patient's vomiting. Every time she had to be cleaned there were verbal and motor expressions of disgust on the part of the parents as well as the servants, more marked in the case of the patient than in that of the sister because the latter did not have so many attacks. Furthermore, there is some evidence confirming the impression that the parents preferred the sister.

As a result of being a twin and thus getting only half the affection and attention due a child—witness the behavior of the mother during the feeding in early infancy—and of the fact that she was the less favored child, she felt an accentuated need to be loved and to receive physical attention—the only criterion for love a child knows. This need for attention was increased by the severe anxiety produced by the paroxysms of coughing and the difficulties in breathing that accompanied them. The attention she received at that time was unpleasant but she put up with it because it relieved her anxiety. Therefore a pattern was established whereby if she experienced any feeling of anxiety she would look for unpleasant attention to mitigate it. Henceforth any situation that produced a feeling of anxiety caused her to wish to attract attention to herself through some form of messy behavior. See, for example, some dreams she had shortly before she went to camp:

• Dream: Patient is with her sister, who vomits, and patient cleans it up.

Dream: Patient is hitched to her sister by a rope and is behind her. The sister vomits, then pulls her down into a deep, dark hole.

Her associations to the dreams were scanty, as they usually are with children. To the first dream she said she would like to be born again and not be thin or crazy. Despite the meagerness of the associative material, the dreams are easy to understand. She was experiencing anxiety about what would happen at camp. In the first dream she identifies herself with the mother and wishes to relieve the sister from the vomiting of the pertussis as she desired the mother to relieve her. In the second dream she would like to receive from the mother the attention both she and her sister got when they were experiencing the anxiety of the whooping

cough. She feels also that she would have been more favored had she been the younger child—being behind the sister.

There is nothing puzzling about the fact that in a jealousy situation she reacted by unpleasant behavior toward the love object. During the pertussis she would naturally get more attention if she were messier. She could also save herself from the sister's jealousy by the fact that the attention she attracted was unpleasant.

However, she could not continue the messy behavior by which she attracted attention because she became too disgusted herself with vomiting to be able to continue to use it as a means of getting what she wanted, and also because she began to strive for some more mature form of love. She therefore repressed her ability to vomit the contents of her stomach and replaced it by verbalization of scatological, antipatriotic, and antireligious expressions. Even though she could not continue to use vomiting as a mechanism, she had to use another oral activity.

Not only did the vomiting during the pertussis accentuate the oral component in this reaction, but the oral component in her need to be loved and to love was accentuated. I have already referred to the method of feeding in infancy, which must have made her feel, at alternate feedings, that she was not getting as much oral gratification as her twin. The method of weaning which I described would also increase her fixation on the importance of oral needs because it contained not only a frustration of oral gratification but also a deprivation of the presence of the mother.

Her aggression against smaller children arose partly from her insecurity as a result of the twin relationship. Her resentment at having to share with her twin gradually spread to other children. Of course, she also dreaded that the mother might have another child. Basically, I believe the mother was more interested in her son than in her daughters, and I know that the patient sensed this. Any child who seems to have a stronger claim on a love object because of helplessness would be regarded as a serious rival. Her aggression arose also from the annoyance and disgust of the adults with whom she was associated during the pertussis. They treated her badly because she was messy or made too much noise. So she came to feel that to be the proper way to behave toward a messy or noisy child and that she had better adopt the same attitude. She showed this identification—partly for the reasons I have just mentioned and partly as a regressive form of love—in her behavior toward smaller children.

(6) Antisocial behavior as a reaction against passive desires.

CASE 52. An eight-year-old boy is referred because of extremely non-conforming behavior, fighting with and attacking most children of his own age or younger. He is not very capable of defending himself with children of his own age, so he has recourse to the use of weapons, throwing stones with an accurate aim and then running, or hitting them with a club. He brutally misuses younger children, particularly girls. Once he attacked a four-year-old girl with a stone and cut her head rather badly. His attacks on other children are so vicious and constant that his parents are required by the school authorities to transport him to and from school in their car. In school his behavior has been so obnoxious that, by the age of eight, he has been suspended from three schools—two public and one private. In the classroom he does not remain in his seat but lies on his desk, walks around the room, hitting at the other children and destroying their work and performing antics in the aisles and in front of the class. These episodes occur most frequently when the teacher is helping another child or when she reprimands the patient. When punished, he attacks the teacher or the principal verbally and physically. He becomes excessively frightened when punished physically.

At home he is very negativistic to both parents, usually doing what he is told not to do and stubbornly refusing to do what he is asked. Isolated because of his behavior toward other children, he plays a great deal by himself, his play comprising mostly running and shooting, during which he makes machine-gun sounds. He destroys the furniture in the house and his own possessions. Everywhere he goes he carries two or more—usually several more—toy pistols.

Every method of punishment from reproof to absolute ostracism and severe whippings has been tried, to no avail. Corporal punishment has been difficult to impose because he is very active and has developed powerful muscles and is very strong.

His defiant, aggressive behavior has been his most outstanding characteristic. Occasionally he has had periods when he refused to eat much, as well as periods of restless sleep and disturbing nightmares. When he tried to control his behavior, he began to stutter.

According to his parents, his violent behavior began rather suddenly when he was four years old. He had a playmate, a girl of his own age next door. One day he refused to play with her and began to call her names and spit at her. The parents placed the blame for his behavior on the attitude of the community, which they felt resented them because they were better off financially. This attitude was more the mother's than the father's.

History. The patient was an only child of elderly parents. The mother was the dominant person in the family and was of a distinctly paranoid character, feeling that the neighbors rejected her because of her higher economic status and having no desire to be friendly with them. As a matter of fact, she never had had friends because she felt no one liked her. She desired a child who would be the perfect little gentleman and who, because of his well-trained, correct, polite behavior, would reflect great credit on her. She trained him as well as she could to this end by constant nagging and punishment. The father was an obsessional character who was unable even to allow himself to feel angry, subordinating his position in the home to his wife and finding what little gratification he could in his business. He obeyed his wife in her plans for the boy's management, although feeling that the boy would benefit by different handling. He knew that he was unhappy with his life and with his wife but could not bring himself either to control or to leave her, lest he hurt her, even though feeling that her rigid social attitudes and peculiar ideas and behavior toward the child were affecting his health and might result in his death. He was unable to apply the physical discipline to the boy that his wife thought he needed or to engage in controversy with his wife because he had a heart lesion and such extra exertion might kill him.

As can be inferred, the boy was raised very strictly by the mother, and she succeeded in eradicating any sign of individuality and masculinity in her child. When he was very small, he had an erection while she was dressing him, for which she beat him so severely that it hurt to sit down for some time afterward. As he grew older, on the other hand, she seemed to desire him to be a real boy and was irritated by any sign of babyishness.

Examinations. The patient's physical examination showed a well-developed, well-nourished, exceedingly healthy boy. His psychometric examination gave him a mental age of over eleven years and an I.Q. of 140. During the psychiatric interviews his outstanding behavior was hyperactivity. He did not sit still a minute. He ran around shooting imaginary airplanes out of the sky and loudly reproducing the noise of machine guns. He paid no attention to rules, tried to break the light fixture and windows, and when prevented threw sand and blocks in the psychiatrist's face. The kinder and more indulgent the latter was, the more destructive the boy's behavior became. Whenever the psychiatrist tried to talk with the boy, particularly about his history, his parents' attitude toward him, or his behavior, he would make the loudest noise possible in order not

to hear. Any attempt at interpretation, no matter now correct, was met by the shouted reply, "That's what you think, but it's a lie." If he did sit down for a few minutes to ask the psychiatrist a question or to tell him something, he was able to maintain the position for only a brief time, beginning again his wild, uncontrollable behavior. I am describing here not one hour with him but hour after hour through many months.

His fantasies were filled with his need to destroy (and so save himself from) huge, dangerous birds or animals—hawks, flying cats, or tigers (all representing females). Even fantasied two-foot-thick bars of steel were no protection against these creatures.

Psychopathology. This mother did her best to emasculate her son, and in order to get along with her he had had to exaggerate and accentuate his passive dependent desires and to suppress any active independent ones. In this she was unconsciously aided by her husband, who was weak and ineffectual and therefore provided an unmasculine model for the boy to imitate. When her purpose had been accomplished, she became dissatisfied with the results and proceeded to force him not to be a sissy. In order still to please her, he had to pretend not to be the passive person he had been but always to be active and aggressive. This was so necessary for him that he actually could not sit still or carry on a pleasant, friendly conversation for more than a very few moments. Unconsciously he regarded sitting still and indulging in a friendly conversation as a gratification of the passivity which he dreaded. Also, he regarded his dependence on maternal affection as a form of the dreaded passivity and so turned his desire for it into fantasies that all women were dangerous objects from which he had to defend himself. His best method of defense was to be active instead of passive. Of course, his defenses also show his identification with the aggressor.

Treatment. The best treatment for him would be removal from his home, placement in a reasonable environment, and intensive psychotherapy to make him conscious of his real desires and his defenses against them. As it turned out, psychotherapy had to be carried on while he lived in his own home and even added to his difficulties. Any attempt to enlighten him as to his real feelings and the real home situation had to be combated by him, because if he changed his behavior at home he would become subject to his mother's wrath and to further punishment. He began to regard the therapist as an enemy who was trying to get him into trouble, part of this reaction developing because his unconscious passive homosexual impulses were stimulated by his friendship with the therapist. He could not tolerate the presence of these feelings and

so projected his desire to be treated by the therapist in a masochistic homosexual manner onto the therapist whom he regarded consciously with suspicion as a dangerous person, as can be seen in the armament he always carried.

It can be seen that each type I have described is complicated by the presence of mechanisms similar to other types, and it is the accentuation of one particular group of mechanisms in each type that causes me to classify them in the way I have. The outstanding factor common to all types is the antisocial behavior. In some of the types, the reasons for it lie in unreasonable environmental pressures that are still present. In others, perhaps because environmental pressures have been exerted in the past, there are peculiar distortions of the superego which is permissive to desires against whose direct expression there is a strong social antipathy and which is restrictive against other desires whose expression, either directly or in a modified form, is permitted and even encouraged by the social organization. There are also peculiar distortions of the ego, particularly in its ability to synthesize the psychic life and in its function of reality testing. In all the types cited so far, there is abundant evidence that a true superego structure exists.

Type 9: Faulty superego construction.

CASE 53. A nine-year-old girl has defied every known legal and moral inhibition of society except murder and illegitimate pregnancy. At first she was afraid that the psychiatrist would punish her for her misdeeds, but as she came to know him better she began to describe her behavior in detail, using all the four-letter words and showing no evidence of superego reactions—shame, guilt, modesty, or fear—about her impulses.

She came from a badly disrupted home where there was no parental affection whatsoever.

It would seem from her case and similar ones that there are certain rebellious individuals who are rebellious because little or no superego formation has ever taken place.

Many of the types I have described are usually designated as psychopaths; but to me the designation is meaningless, because all character disorders show a mixture of inhibitions, sublimations, reaction formations, and delinquency, the basis for which is found on analysis to be in the distortions and defects in the structure of the ego and secondarily of the superego. This mixture is found in Cases 45 and 47. It seems, therefore, more scientific to classify them all as character disorders and in their

management to try to find out why and how the individuals developed such distorted traits. Only by helping them to find out the unconscious and historical determinants of their character traits can one help them to lead a more successful and comfortable life.

Treatment. The psychodynamics of character disorders are usually so complicated that psychoanalysis is required to furnish lasting help to such patients. Its technique, however, has to be altered by the introduction of a preliminary stage—a stage of preparation for analysis—in the type who acts out his intrapsychic conflicts in his environment. This is particularly true in those patients who maintain a relationship of aggressive hatred with their environment. Often such patients unconsciously feel that they would be certain to suffer severe discomfort and pain if they loved anyone. Therefore all love is suppressed or redirected toward themselves. Eventually they appear to have little or no superego and a fantastically heightened power of the ego that sets them above man-made laws. The apparent absence of the superego results from the fact that the only superego characteristic is a great fear of loving and of wanting to be loved—all other impulses being allowed free expression. The aim of psychotherapy in these cases is to remove the fear of loving and of being loved. This fear and the repressed desire to love and be loved is protected by the hostile attitude of the patients to all other people. The hostile attitude is the only way by which such patients can have a relationship with other human beings. Actual psychotherapeutic treatment can thus begin only when the impulses to love and be loved are loosened from their attachment to the individual himself and directed toward another person. A boy of nine steals, sets fires, destroys property, truants, disobeys all parental rules and all community laws, and defies all authority. When brought for treatment he has exactly the same antagonistic attitude toward the therapist. In what ways can the egocentricity of his love life be changed? There are a number of technical devices directed toward this end, the one chosen depending largely on the seriousness of the case.

1. The boy and his parents can come to the therapist together and the parents asked to relate their troubles with the boy present. Since such parents usually have a hostile rejective attitude toward the boy, they readily pour out their complaints and reveal their antagonism. As soon as they are finished, the therapist sends them from the room, turns to the boy, and asks for his side of the story. Since this is often the first time any adult has asked for his opinion or shown an interest in his

troubles, rather than immediately agreeing with the parents and scolding him, he may begin to soften and feel a liking for the therapist. From that point, psychotherapy may proceed.

2. During the interviews with the boy an effort is made to ascertain his deprivations and frustrations. For example, he may have no allowance while all his friends have spending money. The therapist can sympathize with his situation and tell him he will try to get his parents to give him one. When the therapist succeeds, the boy feels that here is a person who is kindlier and more powerful than his parents and responds with love and confidence. There are many methods of this sort that can be used to make the child like the therapist and feel confidence in his ability and co-operation. They should be things of real value and importance to the child, not the mere giving of amusement like taking the child to a ball game or movie.

3. Aichhorn's plan of allowing the child to get into difficulties from which the psychiatrist rescues him as a *deus ex machina* is an excellent one. On several occasions I have deliberately helped a child to undo a delinquency or to escape punishment for the delinquency with this idea in mind.

4. If a delinquent child is cut off from all his delinquent pleasures by placement in an institution, he may begin to give up all his hostile behavior and make his hostile feelings unconscious. This marks the beginning of the development of a neurosis, usually of the compulsive type. He no longer makes the environment suffer from his conflicts but begins to suffer from them himself. When his neurosis has made him unhappy, he is willing to have help with his illness. Psychoanalysis is easy to begin at this time.

CHAPTER FIFTEEN

GENERAL CONSIDERATIONS OF THE TREATMENT OF PSYCHIC DISORDERS IN CHILDREN

IN THIS as in any other branch of medical practice, the most important part of treatment is to understand the pathological changes that are taking place and the etiological factors that are producing the changes. I debated with myself for some time whether to write these last two chapters. Often medical students express dissatisfaction with their course in psychiatry because they do not receive what they consider to be enough instruction in therapy. Such a complaint indicates a fundamental error in (1) the way they have been taught or (2) their understanding of the course material. A similar criticism could be leveled against not receiving adequate instruction in diseases of the lungs because they were not given special sessions in the therapy of diseases of the lung. The student who understands the dynamics of human behavior—the basic concepts of the instinctual life and the defenses imposed from necessity, both reasonable and unreasonable, against their gratification, immediate or otherwise—will need little specific instruction as to the therapy of an individual case. He *will* need help in deciding what cases he can handle himself, what cases need therapeutic treatment, and how he may equip himself properly if he desires to engage in psychotherapy. It is with this end in view that I write these chapters concerning treatment methods. In this review, however, I am basing all that I say on the concept that the

fundamental necessity for any effective therapy is an adequate understanding of the dynamics and pathology of the illness.

The course of development of the child into an adult is one long struggle between the demands for gratification of his instinctual life and the blocking of these demands by several factors. There is first the continual conflict that arises from the fact that the gratification of one set of instinctual drives is impossible if another set is also to be gratified: the creative needs cannot be gratified if the destructive needs toward the same object are also gratified; the need to be active cannot be gratified if the need to be passive also demands gratification; gratification of heterosexual desires is in conflict with gratification of homosexual ones;¹ and so on.

Second, there is the conflict between the demands for the gratification of the instinctual desires in one individual and similar demands for gratification on the part of the other human beings with whom he associates closely, particularly those of the members of his family. Instinctual desires require an object—usually another human being—for their gratification. Therefore the individual has to live in a social group. He has to place restrictions on his need to gratify his instincts because his desires may be in conflict at a given time with those of his associates. For example, if he has an instinctual desire to obtain gratification by hurting seriously a person whom he loves, he has to place restrictions on one desire or the other. In fact, the gratification of some of his desires would actually make family life impossible. Human beings, therefore, from their experience of trying to live together have learned the need to place restrictions on the immediate gratification of their instinctual desires in order to get along in a social organization.

Finally, there is the conflict between the instinctual drives and the customs and manners of the civilization into which the child is born, these customs and manners having developed by trial and error over a long period of time by human beings in their attempt to live together in a social group.

The process of growing up, therefore, consists in the development of mechanisms and skills that will allow the *gratification* of the instinctual needs in accordance with their various aims, and at the same time in abiding by the restrictions imposed by the physical world, the social organization, and the mores of the culture. These mechanisms and skills are often so well developed as to be almost automatic in their action and therefore often act unconsciously as well as consciously in

¹ Franz Alexander: "Über das Verhältnis von Struktur—zu Triebkonflikten," *Internationale Zeitschrift für Psychoanalyse*, 20:33, 1934.

the parts of the personality we know as the ego and the superego. When the child develops a psychosis, neurosis, or delinquency, we know that in some way the development of the ego and superego mechanisms and skills has gone awry. And it is the responsibility of the physician to ascertain how it has gone wrong, why it has gone wrong, and what therapeutic techniques are available to repair the errors in development. The physician has a further obligation: if possible, he must try to prevent the occurrence of ego and superego maldevelopments.

PREVENTIVE PSYCHIATRY

I believe preventive medicine to be the responsibility of the general practitioner and of the pediatrician, whose specialty, after all, is essentially that of a general practitioner for a particular age group—children. But to practice preventive medicine—and particularly that branch that is best designated as preventive psychiatry²—they have to be thoroughly acquainted with the basic facts of the structure of the personality and with the situations and influences that produce pathological disturbances. Physicians who have graduated within the last ten years from the more far-sighted medical schools have usually received considerable instruction in these facts. It was for them, but more for those who graduated from less far-sighted schools or who graduated before the previous decade, that Dr. English and I wrote in such detail about these facts in *The Emotional Problems of Living*, which, as I have pointed out in the Preface, should be read carefully before reading this book.

THE IMPORTANCE OF THE RELATIONSHIP BETWEEN PHYSICIAN AND PATIENT

However, the intellectual and even the emotional understanding of these facts³ by the physician is not an adequate basis for the practice of preventive psychiatry. He must also understand how to use them with his patients. There have always been certain physicians who seem able to help their patients to a better understanding of themselves and of their children, and for some time there has been a feeling that the decline in importance of the general and particularly the rural general practitioner in favor of specialists has been undermining the practice

² I do not like the term "mental hygiene." The terms "hygiene" and "preventive medicine" are not synonymous because the latter includes much more than the former.

of the art of medicine. One reason for the success of those practitioners who have been able to help patients suffering from psychological disturbances lay in the fact that they possessed to a high degree an intuitive—usually unconscious—understanding of the situation. Then, too, the rural general practitioner knew his patients and their families intimately, so that when the adolescent daughter, for instance, consulted him for sleeplessness, loss of appetite, and a generally “run-down” condition, he knew already that the cause lay in some difficulty in her love affairs. He could *listen*, give her some “fatherly” advice, and, prescribing a placebo, send her on her way greatly improved. His patients and their families knew and liked him too, and because they liked him they listened to what he had to tell them, often with an amazingly reverent attitude. The importance of this interpersonal relationship between physician and patient, nurse and patient, teacher and child, lawyer and client has always been known and has been characterized as confidence, trust, and belief.

Some physicians have been successful because they use an authoritative manner; others because they are sympathetically persuasive—the individual approach, of course, depending on the personality of the particular physician. In any case there are certain patients with whom the approach does not work and who quickly change to another doctor whom they “like” better. Freud and all succeeding psychoanalysts have done much research in this phenomenon, which Freud called transference.³ One basic concept is that if patient and physician like each other, the patient is more likely to accept and follow out his suggestions. Conversely, if the patient dislikes the doctor or the doctor the patient, it is unlikely that his advice will be listened to. Thus the old-time rural general practitioner, who was known and therefore “liked” and “respected,” could be very helpful in preventing and improving psychological disorders, while the modern busy urban practitioner, whose patients do not know him very well and therefore have not the opportunity to “like” and “respect” him, has less opportunity to do as successful a job along

³ The reader who is interested in understanding at least intellectually the phenomenon of transference is referred to the following basic papers: Sigmund Freud: “Dynamics of the Transference,” Vol. II; “On Psychotherapy,” Vol. I; “Further Recommendations in the Technic of Psychoanalysis”; “Observations on Transference; Love,” Vol. II, *Collected Papers*, International Psychoanalytic Press, London, 1942. Sandor Ferenczi: *Introjection and Transference. Further Contribution to the Theory and Technique of Psychoanalysis*, Hogarth Press, London, 1926. Ernest Jones: *Action of Suggestion in Psychotherapy*, *Papers on Psychoanalysis*, William Wood & Co., New York, 1923.

these lines, even though his intellectual knowledge of the facts may be far superior.

The interpersonal relationship between patient and physician is the technical device by which adequate preventive psychiatry is accomplished. Therefore, it behooves the physician who is embarking on the specialty of pediatrics and who wishes at the same time to do adequate preventive psychiatry to lay down for himself certain ways of life. In the first place, he should enlarge his professional relationships with his colleagues who practice the specialty of obstetrics so that obstetrician and pediatrician can form a team whose aim is the betterment of development for the anticipated child. It would be well for him to become acquainted with both prospective parents before the child is born. I say *both* parents because the role of the father in the child's early life is as important as the role of the mother, even though there is a tendency in American culture for the mother to take over more and more of the child's management—even of those parts that obviously are the father's prerogative. This tendency is undermining the father's position in the home to the detriment of the psychological development of the child. Strecker⁴ has called attention to some of the results of this tendency. This acquaintanceship must be a professional, not a social, one and is developed by having several conferences—perhaps as often as once a month—with the parents to discuss the subject of greatest interest to both the parents and the pediatrician—the baby.

The establishment of this acquaintanceship has several motives. It produces an interpersonal relationship of a friendly nature based on mutual respect and liking. It gives the pediatrician an opportunity to learn to understand the characters and reaction patterns of the parents and through this understanding to know the most desirable way to help them. It gives the parents an opportunity to discuss with the physician whatever questions about the future management of the child that they have. It gives the physician the opportunity to discuss with them the best methods in the routines—physical and psychological—of baby care. This last implies that the pediatrician himself has an adequate knowledge of the best routines of baby care (i.e., how the baby's dressing, washing, etc., can be best carried out); he understands that babies differ in their innate reaction patterns, as Fries⁵ has pointed

⁴ Edward A. Strecker: *Their Mothers' Sons*, J. B. Lippincott Co., Philadelphia, 1946.

⁵ Margaret Fries: "Psychosomatic Relationships between Mother and Child," *Psychosomatic Medicine*, 6:159, 1944.

out, and therefore require individual management; and that he recognizes that most parents are apprehensive about their ability to handle these routines (particularly if this is the first child), and have prejudices about the physical and psychological management of the child which it is necessary to correct. The average physician apparently operates on the principle that the patient is as well informed on medical topics as he is and often acts as if it were a waste of his as well as the patient's time to impart his greater knowledge in detail and in simple, understandable terms. As a consequence, the patient's need for information which will relieve his honest apprehensions is not met and the apprehensions continue unabated. The publishers of newspapers and magazines and the sponsors of radio programs have recognized and in many instances traded on this state of anxious apprehension, for there is hardly one of these informative media that does not devote considerable space to information about the rearing of children—as well as about health and disease. (Whether the information offered is factually valid or whether it is based on superstitions and prejudices, or presented by frank charlatans, it is desired, and its widespread diffusion proves that it is wanted.) The pressure of the need that calls forth this flood of information and misinformation indicates that the pediatrician and the medical profession as a whole are not fulfilling their professional obligations with their individual patients. The physician will have to recognize that he must give more consideration, and particularly more time, to his individual patient as a human being.

Thus by developing an acquaintance with the parents before the child is born, the pediatrician will be in a favorable position to do good preventive psychiatry after the child is born. If he comes into the family after the child is born, he still must consider the axioms laid down above. And of course whatever information he gives must be based on well-proved facts, if it is going to result in the prevention of neuroses, psychoses, character deformities, or delinquencies.

I believe it was Dr. Johnson who said that any man who was not his own doctor at forty was a fool. People commonly believe they have as much knowledge of medical facts as the best-trained physician. And if this is the common belief in the field of organic medicine, it is even more so in the field of psychology. Most people believe they possess the final truths concerning the psychic life and tend to repudiate, often with scorn, any fact—no matter how well proved—that is in disagreement; and unfortunately this attitude is as common among physicians. The pediatrician, or any other physician who desires to do a competent

job in preventive psychiatry, must divest himself of this attitude and earnestly and humbly apply himself to the task of learning and really understanding the well-proved existing facts of the physiology, pathology, and etiology of disease of the psychic life. If, however, the pediatrician feels he cannot accept them or is not able to understand them, he can do so by scientific means—by undergoing a personal psychoanalysis, as many pediatricians are doing. If he is not willing to do this, then he had better retire from the field of preventive psychiatry and from any attempt to treat neuroses, psychoses, character disturbances, or delinquency in children.

It has been my observation also that the pediatrician who has had children of his own does a better job in preventive psychiatry, particularly in dealing with parents, than one who has not, even though both have had equal training and clinical experience.

I have discussed in earlier chapters the methods of preventive psychiatry which the pediatrician must use in dealing with his child patient. These principles can be utilized in every phase of pediatric practice. Recently I met in Berkeley, California, a group of pediatricians who prove they are actively concerned with the problem. When a new child patient who is very frightened is brought to the office for examination, the office nurse takes him to a playroom where he is entertained. This may be repeated two or three times until the child is completely at home in the office. Then and only then is the examination made. These pediatricians are also concerned with the question of the best method of compensating the child for the pain, shock, and indignity of preventive inoculations. In order to have a more adequate understanding of the psychic side of the child's life, they are not only undergoing personal analyses but also have arranged a series of seminars with a prominent psychoanalyst. They are shining examples to the remainder of the country.

As part of preventive psychiatry, the pediatrician can also concern himself with various educational and sociological reforms of conditions that are productive of maladjustments in children.

As I mentioned earlier, adequate preventive psychiatry depends on the practitioner's having a thorough knowledge of the functioning of the psychic life and of those influences that are likely to produce disorders of function. He can then apply this knowledge effectively in the various practical situations that come under his control. However, he must recognize that the best preventive psychiatry and the very best and most enlightened rearing of children will not prevent entirely the oc-

currence of neurosis, psychosis, or delinquency. Personally I agree more with Reik,⁶ who believes that under ideal conditions of child rearing no serious or permanent disturbances occur, than with Miss Freud, who thinks that it will do no more than materially reduce the incidence.

THE TYPES OF THERAPY

When a child develops symptoms of a neurosis, psychosis, or character disturbance, it is obvious that whatever preventive measures were used have failed. The child now has an illness that requires treatment. What does treatment consist of? The first step is to understand the etiology and pathology—both intrapsychic and environmental—in order that a diagnosis may be made. The diagnosis must include an understanding not only of what group of clinical syndromes the child's illness belongs in but also of the mechanisms that are producing the symptoms. This procedure may and usually does take time, but it is time well spent, because treatment can begin only when an adequate diagnosis has been made. The reasoning I am using here is identical with the reasoning that underlies the consistent medical approach to an organic illness.

THERAPY DIRECTED TOWARD ALTERING THE ENVIRONMENT

The therapy of emotional disorders in children falls into two categories—that directed toward ameliorating adverse environmental influences and that directed toward correcting directly the deformations in the child's personality structure, whether originally the result of adverse environmental influences or not. The child, unlike the adult, is unable to change his environment and is inclined to try to change himself to fit the demands of the environment. If these demands are too inimical to his needs, he will begin to develop pathological forms of adjustment, so that in certain cases therapy must be directed toward accomplishing what he is unable to do—i.e., changing the inimical environment. There is an analogy here with the modern concept of tuberculosis. In evaluating the treatment of tuberculosis, one must consider the seed, i.e., the tuberculosis organism; the soil, i.e., the patient's constitution; and the methods of cultivation, i.e., the patient's environmental situation.

⁶ Theodor Reik: "Aggression from Anxiety," *International Journal of Psychoanalysis*, 22:7, 1941.

In the treatment of emotional disturbances in children, we must evaluate (1) the traumatic experiences to which he is subjected—preventing their occurrence, if possible, and using whatever methods we have at our disposal to ameliorate their effects when they do occur; (2) the constitution of the child, which is unchangeable but which may need special methods of handling, such as I have discussed earlier in connection with the degree of activity; and (3) the environmental influences to which he is being subjected.

These environmental influences fall into three categories:

1. The real physical world.
2. The influence of other people—most notably that of parents, teachers, and older siblings.
3. The influence of the social mores—which in the life of the child are the standards laid down for him by his parents and to a lesser extent by his teachers.

If the child is undernourished, inadequately clothed, or otherwise inadequately provided with the necessities of life because of poverty, if he lives in a delinquency area, if he has insufficient play space, or if he lives in an overcrowded home, these situations must be corrected, if possible. An interesting example of how the child tries to change himself to fit his environment is provided by reports that children in the war-ravaged territories do not show pathological signs of their inadequate diet, nor do they have deficiency diseases to the extent that would be anticipated. Instead, their stature and weight have decreased—the weight-height index remaining constant. They did not have enough to eat to maintain the usual body height and weight, so they redirected their size to one more proportionate to their food supply. Nutrition, housing, slum clearance, wages, etc., are sociological and economic problems which are not the particular field of the physician except in his role as a citizen. But in the individual case he should know the socio-economic status of the family and, if it is low, should attempt to improve it by advice to the parents and by calling on the existing social agencies to help the family—although the resources at the command of these agencies in America are woefully inadequate. It is unquestionably the duty of every physician in his capacity as citizen, regardless of his political opinions, to take part of the leadership in working with organizations—city, state, national, or international—whose aim is the improvement of actual living conditions for children. Also, it is important that he consider the philosophy of the organizations in a realistic and scientific manner and with as little prejudice as possible. I feel it is more impor-

tant in the long run to see that a child who suffers from nightmares as well as an inadequate diet has first a proper amount to eat. After his nutritional needs are satisfied, one can attempt to cure the psychological conflicts that may be producing the nightmares.

It is important in treating a child to ascertain the actual strength of his ego in dealing with anxiety. His ability to deal with anxiety is lessened by the effects of his previous experiences, particularly if they are severe psychologically traumatic ones and if the degree of anxiety is great (this may result from too severe repression of hostility or of sexuality); and by his age—i.e., the younger the child, the less ability he has to tolerate or deal with anxiety. The strength of his ego in dealing with anxiety feelings, instinctual drives, and environment is lessened by fatigue (being kept up too late in the evening, etc.); by sleeplessness (the result of sleeping with other children, of worry, or of fear lest he suffer from unpleasant or frightening dreams); by physical privations (cold, improper housing and clothing, etc.); and by hunger (resulting from insufficient food, from a lack of appetite, or from neurotic vomiting; insufficient food intake as a result of these conditions often results in avitaminosis, the symptoms of which often complicate the neurotic picture). His ego strength is lessened also by a loss of confidence in his parents, by the loss of an ego ideal formed around them, and by otherwise disturbed interpersonal relationships.

The majority of traumatic experiences emanate from the environment and are usually ones that occurred in the past; or, if they are operating in the present, their influence on the child can be easily stopped. However, this is not the case with one traumatic situation—the adverse attitudes of the parents, in which case it is often impossible to do much to help the child unless the behavior of the parents toward him is modified.

THERAPY DIRECTED TOWARD PARENTAL ATTITUDES AND BEHAVIOR

The therapy to be used depends on the psychodynamics of the parents' behavior. If the parent, because of the influence of his own upbringing, is ignorant of the fact that a child has certain needs that have to be satisfied, that the behavior of a child at one age period is different from that of a child at another age period, or that the behavior of a child of one sex is different from that of a child of the other sex, then instructional measures can be used. Instructional therapy does not consist in telling

the parent that he is handling his child incorrectly and expecting that without hesitation he will listen and accept the physician's directions. Its dynamics are something quite different. Instruction consists of a combination of suggestion, persuasion, and reason. The basis for these methods of psychotherapy lies in the relationship, conscious and unconscious, of the patient to the therapist. If the patient has many strong passive submissive trends, he may accept the authoritative approach. Many physicians consistently use an authoritative approach, which is often accepted by patients because they regard him with awe and reverence as if he were endowed with the magical attributes of the primitive medicine man. Similarly, the authoritative teacher is attended to with awe and reverence by the child because he is endowed with the magical powers of the parent. The parent or child may try hard to accept the teachings of the authority and may try to carry them out, but the whole process stultifies his own ability to think, and when another problem arises he has no methods to deal with it and has to return to the doctor for further help. The use of an authoritative attitude to dispel the patient's ignorance causes the latter to regress psychically to the status of a child, and the doctor becomes a stern and firm, if essentially kindly, father whose will must be obeyed.

Another method of instructional therapy consists in persuading the patient to change his point of view, not because he has been ordered to but because he knows such a change will please the physician, whom he admires and likes. In the patient's mind, the doctor becomes a kind, tender parent whom he wishes to please in order that the doctor will like him. Such a physician often tries to further his relationship with the patient by quoting authorities, counseling him to read certain books, etc.

It will be noticed that I have said nothing about the patient accepting the physician's advice and suggestions because the physician is stating facts. The acceptance of facts, simply because they are facts, really should play a much more important role in life than unfortunately it does. Practically, the relationship between the patient and the physician plays a very much larger role in instructional therapy. This is the case in all education. The most important role in all learning consists in the relationship between pupil and teacher. There is no objection to the use of instruction as a method of changing the parents' behavior toward the child when their behavior is the result of ignorance. Thus it is a valuable treatment method, and the physician should be aware of its

psychodynamics. It is not applicable to every case and often fails to accomplish its aim.

A parent's behavior toward a child may be the result of prejudice rather than ignorance. He may be prejudiced against a form of infantile erotic gratification that is appropriate to the child's age, against some form of expression of aggression again appropriate to the child's age, or against permissive training, the prejudice usually being the result of some intrapsychic conflict in the parent's mind: he is too afraid of certain instinctual desires of his own and so condemns them in others. This situation obviously cannot be dealt with by instructional methods, which add to the reality-testing function of the ego. Here, treatment methods that will produce a modification of the superego are required.

Sometimes the parent's intrapsychic conflict is not too severe and therefore the solution of the conflict—i.e., the prejudice—is not too fixed. In such cases suggestion and persuasion based on an understanding of the interpersonal relationship between patient and physician can be effective. A knowledge of the degree of fixedness of the prejudice is obtained rather easily in three or four interviews. Whether this method of treatment is to be continued or not depends on an evaluation of its depth: the more fixed the prejudice, the more likely it is to be part of a neurotic character structure and therefore the less amenable to suggestion and persuasion, even if accompanied by detailed instruction in psychodynamics either by the physician directly or through the use of selected reading by the patient.

THERAPY OF PARENTS WHO HAVE CHARACTER NEUROSES

The parent with strongly fixed prejudices is in reality suffering from a character neurosis. So, also, is the parent whose behavior toward the child is associated with marital and vocational difficulties, delinquency, overhate, overprotection, or indulgence of the child. Parents who suffer from frank neuroses—conversion and anxiety hysteria and compulsion neurosis—may also manifest adverse behavior toward the child as a symptom of their neurosis, but they are too ill to be helped regarding their behavior toward the child by instructional therapy. Their illness lies outside the function of the nonpsychoanalytically trained physician and is too complicated in structure for him to attempt to treat. There are also parents whose behavior toward the child is the result not of neurotic character but of ambulant psychosis. Although they seem to get along, they are actually psychotic people. For such cases, even psychoanalysis is frequently of little help.

THE EDUCATION OF THE PHYSICIAN
IN PSYCHOTHERAPY

I believe that in a discussion such as this, it is impossible to instruct students in psychiatry in adequate therapy—even such therapy as suggestion, persuasion, and ventilation—for instruction, to be fruitful, must be obtained through lectures on the principles of suggestion and persuasion, and then through conferences with a well-qualified instructor on the material in individual cases that the student is handling by the trial-and-error method, and by group-conference discussion between groups of students and a well-qualified instructor. The basic requirements for such instruction as will qualify a physician to practice psychiatry are laid down in the regulations and requirements for the examination of the National Board in Psychiatry and Neurology.

For the vast majority of severely ill patients, psychoanalytic therapy offers the greatest hope of real cure, or at least of a real amelioration of the neurosis. Such treatment can be given only by a qualified psychoanalyst, whose training comprises three stages:⁷ “. . . His personal analysis which is a basic and indispensable preparation for psychoanalytic training. In this analysis the prospective student undergoes a penetrating psychological study of himself. He is expected to explore resolutely and thoroughly the unconscious reaches of his mind, trace his development back to the formative experiences of his childhood, and arrive at a better knowledge and more realistic appraisal of himself as an individual and as a product of a given period and culture. He is expected to overcome his personal difficulties and acquire a greater measure of self-direction, psychological and critical independence, and a more mature outlook upon life. This personal analysis shall be on the basis of at least five hours a week. The duration of the preparatory analysis depends upon the needs of the individual and shall be determined by the analysing instructor.” After this the student attends an intensive series of lectures on the theories of psychodynamics and psychopathology, a series on the technique of therapy, and a series of at least fifty clinical group conferences with an instructor on the therapy of individual cases. During this time he treats at least four patients, each for one year, under the supervision of different analyzing instructors. This supervised clinical work must continue until it is the consensus of opinion that the student's work has attained maturity. Such training

⁷ Bulletin and Catalogue of the Philadelphia Psychoanalytic Institute.

is given only to students in psychiatry who have had at least a year's clinical supervised work in psychiatry.

Owing to the length of time that the analysis of a patient usually takes, methods have recently been suggested for shortening the analytic technique.⁸ These methods, which might be designated as psychotherapy based on analytic knowledge, seem to have produced favorable therapeutic results, although the whole procedure has not been subjected to the test of time. Dr. Leon Saul,⁹ who is well acquainted with this newer form of psychotherapy, believes—and is certain that Dr. Alexander and Dr. French believe—that only an analyst who has had at least ten years' experience in the use of orthodox psychoanalytic therapy is competent to use the new form of psychotherapy.

I want to make clear that very often the intrapsychic problems of parents whose attitudes toward the child are unfavorably affecting his development are too serious for the nonpsychiatrically trained physician or even the nonanalytically trained psychiatrist to undertake to treat. And I seriously question the advisability of the present tendency to try to teach psychotherapeutic methods and techniques to nonanalytically trained general practitioners or to those who practice other specialties, such as internists, pediatricians, dermatologists, endocrinologists, etc. Of course, the more all physicians understand psychodynamics and psychopathology, the better they can practice medicine, but the understanding does not in itself qualify them to treat psychoneuroses, psychoses, or delinquencies.

What, then, will be the therapeutic role of the general practitioner or pediatrician when a parent consults him about his psychoneurotic, psychotic, or delinquent child? His function will be to refer the case to a child analyst, a procedure not as easy as it sounds and one requiring great skill on the physician's part. For in spite of the influence of newspapers, magazines, and the movies¹⁰ and all the knowledge gained by servicemen and their families about psychiatry, even the educated man regards the psychiatrist with fear and dislike, as if he were a

⁸ Franz Alexander and Thomas M. French: *Psychoanalytic Therapy*. Ronald Press Co., New York, 1946. (The title *Psychoanalytic Therapy* is a misnomer and is therefore misleading, since the book does not deal with psychoanalytic therapy but with psychotherapy based on analytic knowledge.)

⁹ Personal communication.

¹⁰ My main objection to the movies in which psychiatric treatment of the psychoneurotic is portrayed is that in the portrayal the cure is accomplished in too easy a manner and in far too short a time, so that the lay public gets the impression that treatment is relatively easy and takes very little time.

sorcerer in association with evil forces. Most persons feel greatly humiliated at being asked to consult a psychiatrist, and the physician who makes the referral must have a good relationship with the parents and from this firm base use the methods of suggestion and persuasion tactfully. This may take a number of interviews, but the time is well spent.

REMOVAL OF THE CHILD FROM AN ADVERSE ENVIRONMENT

There are certain cases where it seems desirable to remove the child from his home either temporarily or permanently. I am discussing here placement as a therapeutic prophylactic measure and not that made necessary for children whose family group has dissolved because of the disasters that attend human life—death, separation, divorce, serious parental illness, either physical or mental, etc. Placement for therapeutic measures may be necessary for several reasons: the child's behavior may have reached the point where it serves as such a constant irritant to the parents that they cannot change their reactions to him; therapy may not be available, or may not be able, to improve the parents' attitudes toward the child in a reasonable period of time; the community and the school may be bitterly antagonistic to the child or contribute in other ways to his difficulties in development.

It must be remembered that the use of environmental change as a therapeutic measure is a serious matter. Our culture emphasizes the family group as a self-contained and self-sufficient entity. The parents are expected to rear the children and the children to submit to being reared by their parents. On the other hand, in a culture such as Mead¹¹ found in Samoa, if a child gets annoyed with the way he is being handled, he goes next door to live for a number of months or for as long as he pleases. This sort of behavior is frowned on in our culture. The disruption of family ties by the removal of the child to another home becomes a serious matter and becomes a traumatic experience in the child's life, regardless of the need for the placement. Almost invariably he feels that placement is a punishment for some crime he has committed, adding another trauma to a child whose development has already gone awry from too many traumatic experiences. Furthermore, placement is often not the only therapeutic measure needed.

An environmental change between the ages of birth and six years will be more effectual because the personality structure is not yet

¹¹ Margaret Mead: *Coming of Age in Samoa*, Morrow, New York, 1928.

organized. After six or seven, the personality structure is more organized and therefore is less influenced by a new environment. This is particularly true in cases of psychoneurosis, where the personality structure is too rigidly organized, in which case placement in even a much better environment often results in the environment's being changed rather than the child! Placement has little direct therapeutic influence on the adolescent unless accompanied by intensive psychotherapy.

Children under puberty whose development is suffering because of a lack of kindly and consistent educative measures or whose parents are leading them into asocial or antisocial ways receive much therapeutic benefit from placement in a different environment. At and after puberty such measures render progressively diminishing returns.

The therapeutic aims of placement achieve the best results when the child is in the period of infancy—i.e., under six years—and when the placement is permanent and ends in adoption—the younger the child and the earlier the legal adoption, the better. In fact, placement during the first few years of life is much more a prophylactic than a therapeutic procedure. If placement is made toward the end of the infantile period (i.e., four to six years), or during latency and early adolescence, if it is not terminated by adoption, and if the child is in too frequent communication either in person or by correspondence with his own parents, the therapeutic aim—i.e., the amelioration of the severity of the superego or the inculcation of more useful ego ideals—is seriously interfered with. In such a situation, the child has a serious conflict between his loyalties to his own parents and to his foster parents and tends to become too un-aware of his ambivalence since he can direct his hostility toward one set of parents and his love toward the other. He never has to come to terms with the fact that he is an ambivalent person who loves and hates the same object at the same time. As a consequence, later on he will show a defect in the synthetic capacity of his ego and will always be finding an unrealistic scapegoat as the object either of his loves or of his hostilities.

There are three reasons for placement:

1. To provide a child with a satisfactory home and perhaps also with a family.
2. To provide a child with a decent home with reasonable substitute parents while the child is undergoing psychotherapy.
3. To provide a child with a decent home and reasonable parent substitutes as a therapeutic measure in itself.

In another place ¹² I have discussed the psychological difficulties im-

¹²O. Spurgeon English and Gerald H. J. Pearson: *The Emotional Problems of Living*, London, George Allen & Unwin, pp. 98-99.

posed on the child by the process of placement. I mentioned earlier that therapeutic placement, with or without the use of psychotherapy, may be either temporary or permanent, in a foster home or in an institution.

TEMPORARY PLACEMENT

For temporary institutional placement there are many social resources—summer camps, hospitals, and boarding schools for children of most economic levels. The financial pattern is familiar: the lower the cost, the less desirable the institution, except when it caters to the marginal economic group, where the management is usually in the hands of a capable social agency. No child should be placed in one of these institutions unless such placement is part of a well-defined therapeutic plan based on a real knowledge of the etiology and pathology of his disorder. Furthermore, the institution, its management and policies, and particularly the state of psychic adjustment of the staff members should be thoroughly investigated. We should be cautioned that adults with perversions tend to gravitate toward employment in child-care institutions, where, under the guise of professional interest in children, they have greater opportunities to practice their perversions. It is well known that overt homosexuals are frequently found as teachers in boarding schools, as counselors in camps, and as house parents in orphanages—even when the institutions are state-examined and state-licensed.

Temporary placement in a foster home can be used also, and again should be made only on the basis of a thorough understanding of the dynamics of the case. The foster home—and particularly the personalities of the foster parents and their real reasons for accepting children in their home for a limited period of time—should be investigated carefully. In the present state of American social planning, such homes are selected best by a well-recognized child-placing agency. Probably the best reason for foster parents undertaking the care of children in their home is a financial one, but unfortunately, because of our inadequate awareness of social problems, there usually is insufficient remuneration to attract the best class of adults to the management of foster homes.

PERMANENT PLACEMENT

More permanent placement, too, can be made in institutions, foster homes, and boarding schools. There are, of course, orphanages, whose purposes are not therapeutic, and corrective legal institutions such as reformatories. The number of therapeutic institutions, however, is far too small. The few that exist are, when adequately staffed, extremely expensive, and when less expensive, are very inadequately staffed. I believe

that in the social planning of the future it will be advisable to consider the need for in-patient hospitals for children who suffer from intrapsychic disorders. Each city of more than 100,000 population throughout the nation should have at least one such hospital, organized to provide adequate living conditions and schooling and at the same time a sufficient amount of psychiatric and psychoanalytic therapy and designed to serve not only the wealthy and the indigent but also the middle-income group. The personnel of these institutions will have to be selected carefully to avoid the dangers we have noted. They will find a unique place in the therapeutic regime for the many cases of intrapsychic disorders in children—a place that cannot be filled by the foster home. The trend of recent years away from institutional toward foster-home placement has been a good one, but the needs of children suffering from intrapsychic disorders have still to be considered.

Permanent placement in a foster home can be used as a therapeutic measure, but the home must be selected carefully to meet the needs of the individual child. Selection should be made through conference discussions of the case between the psychiatrist and the workers of the child-placing agency, the responsibility for the selection resting with the agency. However, the regulations of the agency—whose experience is more commonly with the general placement of children—may have to be modified if the foster home is to be used as a therapeutic measure. It has not been my experience that child-placing agencies consider seriously the difference between the use of a foster home to provide a home for a homeless child and its use as a therapeutic measure for the child. It seems to me also that most child-placing agencies suffer from a lamentable unawareness of the need for psychiatric consultation about such cases.

In the case of children whose behavior as a result of their intrapsychic conflicts is antisocial, foster-home placement is undesirable. Their behavior arouses too much justifiable hostility in the foster parents and community, and eventually in desperation the foster parents reject the child. Many children with antisocial behavior have a record of short placements in a great number of foster homes—each unsuccessful placement, of course, adding to the child's intrapsychic difficulties. Too, foster parents usually find it difficult not to criticize, scold, and be disgusted and offended by children with marked compulsive symptoms, with severe tics, or with major or minor perversions. They usually cannot understand psychotic children, except when they themselves have accentuatedly schizoid personalities, and then they too are of no therapeutic

use, since they are frightened by the open exhibition of what lurks in the depths of their own unconscious minds and as a result tend to reject the child. These reactions are found not only in foster parents but also in the personnel of those institutions that are not basically for therapeutic purposes. These types of cases do poorly in foster-home placement and in placement in ordinary institutions.

THE AIM of environmental therapy is to give the child a better place in which to live. This is accomplished either by placing him in a new environment—home, school, class, neighborhood, etc.—or by changing the adults' attitudes toward the child—parents, teachers, etc.—through therapy. Environmental therapy is an important prophylactic measure, as we saw in the previous chapter, for children who are beginning to develop a psychic illness because of adverse environmental situations, though not in itself so effective for children who have already developed a psychic illness (as have most of those discussed in this book) and who will therefore need treatment techniques whose purpose will be the solution of their intrapsychic conflicts. The child cannot change his living situation as the adult can during or after his period of treatment. If the environment, particularly the attitudes of the parents toward the child, has been inimical to his development, it will also be inimical to the progress of his treatment. Therefore, in addition to psychotherapy for the child, therapeutic measures will have to be directed toward ameliorating his environment. The age of the child and the degree of environmental pathology are two indications for the use of adjuvant environmental therapy.

Between birth and the age of six or seven years—i.e., during the prelatent period of life—the child is dependent on the interplay of his feelings of love and hate toward his parents and on his identifications with them for the formation of his ego and superego. The attitudes of his parents toward him are of the greatest importance in his life. Moreover, if he develops a pathological intrapsychic conflict during this period *even though the conflict is not the result of adverse parental attitudes*, the conflict begins to play a part in the parent-child relationship, often producing adverse parental attitudes, especially if such a tendency is already present.

CASE 54. The mother of a boy of six complained that she felt little affection for her son because he was so unresponsive to her and because his behavior was so annoying. She tended to be a rather cold, unresponsive person herself. The boy's apparent lack of affection was his way of solving his pathological intrapsychic conflicts. As he improved during treatment, he became more able to love, and the mother reported that she felt more loving toward him, his behavior indicating that the report was correct. The child's solution for his conflicts was rapidly producing an adverse attitude in the parent, which, if continued, would have resulted in the development of more conflicts in the child.

Adverse parental attitudes interfere with the successful therapy of a child who has a pathological conflict during the prelatent period, whether the adverse attitudes are the cause of the conflict or not. If they *are* the important etiological factor, success by treatment of the child alone is almost impossible, for even if it could be accomplished successfully, the child, cured of his former conflicts but in the formative stage of development, would have to continue to live in a noxious situation to which he could adjust only by developing new conflicts and new symptoms. Thus in the prelatent period, treatment for the child must be accompanied by treatment of the parents' adverse attitudes, and the younger the child, the more important it is that the parents too be treated.

During the latency period, particularly during the early part, the same procedure must be followed; but toward the end of this period, treatment for the child may be successful without treatment of the parents. In adolescence, it is quite regularly so accomplished.

In all cases, the co-operation of the parents is necessary for the successful treatment of the child.¹ This is true even for children who are

¹ For some of the material in the following paragraphs I am indebted to the Report of the Panel of the Committee on Indications and Criteria for the Psychoanalysis of Children and Adolescents, which was part of the Annual Meeting of the American Psychoanalytic Association at Washington, May 15, 1948.

being treated by psychoanalysis. However, with children who have the ability to so project their superego demands and id wishes onto the analyst as to establish a transference, neurosis can be analyzed with the minimum co-operation on the part of the parents. This usually holds true only after the decline of the Oedipus complex.

The type of illness from which the parent suffers is important. If he is seriously ill, the child should be taken for treatment regardless of his age. If the parent's illness is not so severe, it becomes necessary to decide whether to treat the child or the parent only. In children, certain psychosomatic conditions like colitis, asthma, and dermatitis seem to depend on a specific relation between mother and child. The mother unconsciously tries to keep the child helpless, looking on the child as if he were part of her body, and the child reacts by obedience, dependence, helplessness, and illness. Thus treatment of the child will be ineffective unless the mother is herself helped by treatment to an understanding of her own unconscious motivations. In cases where faulty education has disturbed the life functions, such as sleeping, eating, cleanliness, speech—particularly when the child patient is a preschooler—some work with the parents, particularly the mother, is essential. Children who are entirely dependent on their environment, particularly on the mother, whose well-being and feelings are dependent on her approval or disapproval, and who are unable to form independent judgments come within this group. Here it is especially necessary that the analyst work closely with the parents lest treatment be terminated abruptly—as often happens, the greatest number of failures occurring in severely neurotic children with untreated parents. Fortunately there are mothers who are intuitively warm and loving and who help treatment by altering the environment when necessary.

The more loving types of parents are helped by educative and supportive therapy. Other types require treatment for themselves, perhaps even psychoanalysis. However, difficulties are sometimes encountered when the parent is under analysis at the same time as the child. She may talk to the child's analyst about her feelings of jealousy but not really understand them and instead act them out on the child. Or she may become frightened at realizing her own responsibility for the child's neurosis and come for advice, which she uses punitively against the child as a sort of wild psychoanalysis, often not even bringing this part of her problem into her own analysis. Perhaps it might seem well for the two analysts to get together and discuss the situation, but even here difficulties may be raised by the countertransferences of each analyst.

Most parents, because of time and other factors, cannot profit either by education or by analytic treatment, in which case a special technique is required, one of handling the transference situation and of guiding the parent's associations toward the unraveling of the problem in the parent-child relationship.

It is the general opinion that the same analyst can work satisfactorily with both the child and the parent at the same time, particularly where the therapy with the parent is supportive and not psychoanalytic. First the child's confidence is gained so that he feels that he and the therapist are allies, after which he will permit the analyst to work with the parent to help him. A male analyst serves best under these circumstances. In most instances, however, it is better when one analyst works with the child and another with the parent, both, moreover, being equally experienced in working with children. In fact, the ideal situation is one where there is reciprocity between the two analysts, one working with a child, the other with the child's mother; the second one working with another child and the first one with that child's mother. The resulting relationship enables the two to collaborate on their cases and helps them in the discussion of the countertransference phenomena.

PSYCHOTHERAPY OF CHILDREN

As we have seen, for most of the cases discussed in this book, treatment for the parents is used only as an adjuvant to the direct treatment of the child. In order to discuss the psychotherapy of children, the various psychotherapeutic methods, and the criteria for the selection of cases suitable for psychotherapy, it is important to understand the purposes of psychotherapy, which are illustrated by the following case.

CASE 55. A girl of thirteen suddenly developed a feeling of weakness in her legs which made it impossible for her to walk and as a result, kept her from her usual occupations—school, playing with other children, etc. Two weeks before her legs became weak, she had been invited to go to the home of two school companions to listen to the radio and dance, both of which activities were forbidden by her parents and by her religion and were associated in her unconscious with ideas and feelings of sexuality which were prohibited by her severe superego. So she refused. During the next two weeks her friends teased her a great deal about her refusal, which hurt her feelings and made school so unpleasant that she wanted to stay away from it. But if she did so she would be scolded by her parents and criticized by her superego. She was unable to visit her friends

because then she would be tempted to engage in activities which she believed to be wicked and for which she feared punishment by her parents and by God. In order to avoid her fear of her parents and of God's displeasure—i.e., her feelings of guilt—she refused to go with her companions. She wanted to stay home from school in order to avoid the painful suffering of the teasing, but the avoidance of her duties would arouse pangs of conscience. She found a good compromise to her conflict in the weakness of her legs: she could not walk; therefore, she could not visit her friends or go to school. Thus, like all maladjusted persons, she was curtailing her life in order to avoid situations or acts that would result in feelings of guilt and fear.

The purpose of psychotherapy would be to relieve her of these feelings of anxiety, fear, and guilt about doing, thinking, and feeling what other girls of her age do without any such discomfort. This might be accomplished by changing her concept of God, by assuring her that God was not a punitive deity and did not consider the behavior of her acquaintances or her own thoughts and feelings to be wicked. Her concept of God, however, arose from three sources—her religious teaching, the precepts of her parents, and her own superego. The first was conscious; though the second was also; another part was unconscious, having become part of her personality through her early training; the restrictions imposed by her superego were unconscious. The attempt to change her concept of God, therefore, would have to be accomplished through making her unconscious conscious.

She felt that her desires for the pleasures or gratifications permitted to the ordinary child were an expression of wicked disobedience against her parents and their training now and in the past, and were equivalent to hatred of them. Psychotherapy might be directed toward getting her to recognize that her parents were overrestrictive and toward pointing out ways by which she would be able to satisfy her desires and get along with her parents at the same time. But she could not recognize that her parents were restrictive because that would be criticizing them, and criticism would be an expression of a feeling of hostility. So psychotherapy might be directed toward helping her recognize and express, during the treatment hour only, her long-stored-up hatred of her parents because of their restrictions; through the draining off of the pent-up hatred, she would be better able to tolerate her normal aggressive feelings and to use them when necessary. It might be directed toward ascertaining and making conscious the instinctual impulses that lay hidden behind her desire to dance and listen to the radio and to the circum-

stances in her childhood that caused her to fear a catastrophe to herself when she tried to express them in their infantile form. In brief, psychotherapy would be directed toward relieving her of her feelings of fear and guilt concerning her thoughts and feelings and her desire to behave like other children. It might be thought that this could be readily accomplished by educating the parents toward less prejudiced attitudes and by reassuring the child that there was no real cause to be afraid. However, as yet she has never verbalized her desires, her feelings, or the real content of her fears and, in fact, has not allowed herself to be conscious of them. Under these conditions, reassurance would be meaningless to her. The most important part of psychotherapy would have to be directed toward making conscious the impulses associated with the situations about which she feared punishment and allowing her to express them, or by making conscious the impulses underlying the desire to behave like her friends and the childhood circumstances that caused her to think that the expression of these impulses would result in a real catastrophe to her.

THE INTRAPSYCHIC OBSTACLES TO SUCCESSFUL PSYCHOTHERAPY

THE PATIENT'S RESISTANCES

The purpose of psychotherapy is to relieve the patient of unreasonable and unnecessary feelings of guilt and fear about doing things that the ordinary person regards as reasonable and desirable. The relief of such feelings by psychotherapy is difficult for two important reasons.

First, the nuclear circumstances that produce the fears of expressing inner desires and impulses usually occur very early in life. They result from the fact that the individual is born with inner impulses and desires that demand immediate gratification and because the main activity of childhood lies in trying to obtain these gratifications in the face of the opposition of reality and of the human society in which he lives. A child may have a desire for candy because it tickles his palate. If he gorges himself to gratify this desire, he will become nauseated and vomit. The reality of an acute gastrointestinal upset opposes any further desire for unlimited gorging. If his parents do not believe in allowing him for unlimited gorging. If his parents do not believe in allowing him candy, they may punish him painfully if he tries to satisfy his desire. His desire for candy in the future must reckon with the human society in which he lives. As result of either or both situations, he has to limit and alter the expression of his desires lest he suffer painful consequences.

When next the desire to eat candy occurs, he has to try to adjust it to the two sets of experiences he has undergone in order to avoid a repetition of the pain. If the suffering from his illness or from his parents' punishment has not been too great, he will learn to eat only small or permitted amounts. If the suffering from the punishment has been great, he will attempt to avoid its repetition by becoming *unconscious* of a desire for candy. The unconscious desire will show itself under various disguises:

1. He may act and feel as if he loathed candy. Here the desire appears as its opposite.

2. He may become engrossed in selling candy to other people to eat. Here his desire for candy appears as a desire for other people to have it.

3. He may be nauseated at the thought of candy or become ill if he eats only a little. Here he suffers discomfort for gratifying the desire.

4. He may eat a little candy and then get himself into some trouble for which he will suffer punishment. Here he admits the desire but has to make restitution for having it.

The candy illustration is, of course, a simple one. When its principles are applied, however, to the deep impulses of sexuality and aggression, the results are the same. These impulses have many forms of expression and are the basis for all our actions and relationships in life, so if one of their manifestations comes under the sway of an excessive fear, all the manifestations may do so. From that point on, the individual, in order to avoid a repetition of the suffering, develops patterns and defenses that serve to alter the various modes of expression of the impulse lest the impulse appear and its associated suffering recur. The desire may be repressed out of the conscious. In order to keep it repressed, the repression will have to be aided by changes in the character, the person seeming actually to prefer to do the opposite of the impulse (reaction formation); the impulse may express itself in a method very different from its original mode of expression (sublimation); the impulse may be expressed accompanied by a feeling of no pleasure or perhaps by actual pain (hysterical symptoms); or the impulse may be expressed and the individual then hurt himself as punishment for having such an impulse (obsessional symptoms). As time goes on, the unconscious impulse becomes stronger than the reactions against it and the individual tends more and more to seek to gratify the original but now unconscious desire. This is well illustrated by the following case:

CASE 56. The patient is a girl of twelve years. Between the ages of four and five and a half she slept in the same room with her brother,

and sex play occurred. Then the children were separated and the boy, because he was getting older, stopped the sex play. The girl wanted to continue but did not dare demand it openly lest her parents find out. She became very angry with her brother and wished he would die. About this time, she saw the body of the brother of a friend of hers laid out and immediately began having nightmares that she had died. These lasted until she was ten, and during this time she and her brother got along in ordinary brother-and-sister fashion. About the age of ten she deliberately tried to get rid of her nightmares and was successful. But her behavior toward her brother changed: she became openly antagonistic toward him, tried to boss him, told tales on him, destroyed his valued possessions, and constantly engaged him in physical combats such as wrestling. At the same time, she could not understand why he did not like her and would not take her to dances and movies.

The course of her defenses is interesting. She first reacted angrily to her brother's frustration of her desire. Then she repressed the desire and her anger at the frustration, the complex appearing only in her nightmares which told her that she was such a bad girl to want sex play from her brother and to be angry with him and wish his death that she ought to be punished. The suffering of the dreams was great, so she successfully repressed the anxiety. With this repression, her attitude toward her brother changed. She started to annoy him but without any idea that the behavior was an attempt to attract him sexually. Too, her amazing behavior incurred the parents' displeasure, but now she could reason that they favored the brother over her. It was their fault instead of his. If these devices of defense against the original impulse and the fear of it continue long enough, the individual tends to find the devices useful for other purposes—as this girl did. She found that her behavior toward her brother directed the attention of her father from the brother, whom he really favored, to herself and also caused quarrels between the father and mother. Her defenses then increased her importance in the home, which gave her pleasure.

The stronger the defense devices are, the less anxiety appears. The more adequately the defense devices bring gratifications of other needs—possessions, success, control, power, etc.—even though to an outside observer these secondary gains do not seem to outweigh the losses incurred through the many restrictions of the original impulse, the more useful they become and the less the patient is willing to give them up. In Case 55, the girl relinquished her school achievement, social and recreational interests, and love relationships with her friends, seeming

content to do so because she was able to find pleasure in basking in the regard of her parents and in the pride of her virtuous moral life.

Probably the most serious defense device and the one that interferes most with psychotherapy is narcissism. At the beginning of the child's development, all his positive feelings are directed toward himself, and as he comes to concepts of himself, this direction of his positive feelings gives him a sense of power and grandeur which is really delusional. But the more he turns his positive feelings to other people, the more his grandiose ideas are diminished. Later, however, if he should meet an overwhelmingly frustrating obstacle, he may withdraw his positive feelings from other people and turn them back on himself; whereupon he will begin to feel all-powerful and to believe that his difficulties are not due to himself but are the fault of other people; he feels little need for help from anyone else. Such a defense against treatment is almost impregnable. Two illustrations of the effects of narcissism are pertinent here. Children who are chronically aggressive come to treatment with an open, hostile attitude toward the therapist. It is often surprising how a child of six dares to destroy the property of a strange man and to defy him openly—surprising, that is, until one considers that the child has a feeling of omnipotence, a feeling that he can do as he likes and that no one can hurt him, which arises from the fact that all his positive feelings are directed toward himself and that because he loves himself so much, he attributes all virtues to himself. In this he is like the schizophrenic patient, though to a lesser degree. Schizophrenics are indifferent to others and interested only in themselves. They feel omnipotent and omniscient; i.e., they are all-powerful and know things that are unknown to others. Thus because of this power they do not feel the need for therapeutic help. They cannot conceive that their difficulties are of their making but believe, rather, that they result from other people's antagonism. Their feelings and consequent behavior are exactly the opposite to that of the man in love who attributes all virtues to the object of his affection because he is in love. The schizophrenic, and to a lesser degree the child with a chronic aggressive character pattern, attributes all virtues to his love object—himself.

Narcissism, therefore, serves as a serious barrier to psychotherapy. The patient believes that other people or influences are responsible for the difficulties he encounters and that he is immune from the ordinary cares, tribulations, and needs for adjustment encountered by human beings. A very narcissistic person has no recognition that he himself is ill and out of step. He has no secondary insight—insight into the fact that

he is ill because of psychic fears and is in need of psychotherapeutic help to be rid of them.

Thus a person comes for psychotherapy not with one simple problem but with many overlays of defense devices; and the longer the time since the original conflict occurred, the more powerful and manifold are the defense reactions. As a result, the patient often does not know the nature of the impulses he dreads or even the precise nature of the dread. The powerful nature of the impulse that demands expression and the conflict between it and the fear is often carried into other situations that differ greatly from the original conflict, and the patient is very puzzled as to the reason why he has so much trouble in his life.

As we have seen, the defenses themselves acquire a pleasure that the patient is loath to give up (secondary narcissism). In Case 56, for example, we saw that the girl's behavior toward her brother attracted the father's interest to her. The degree of secondary gain depends on the duration of the illness and the attitude of the relatives and friends toward the sick person. If the gains are great, they constitute a serious resistance to psychotherapy.

Psychoanalytic research has shown that a patient may consciously feel the need for help and want to be well, but unconsciously have the opposite attitude. He does not wish to lose the pleasure of this secondary gain, but this is only of minimal importance; his resistance to getting well results actually from his childhood fears of being punished by castration and loss of love. His conscious desire for good health is all that the therapist has to hold to, the degree of the desire being in inverse ratio to the degree of adjustment that has been accomplished by the defenses against the return of the anxiety.

Basically, all of these defense reactions can be grouped under the biological reactions to danger: attack on the source of danger, or flight from it. Sometimes the attack is made on the danger as if it originated in the outer world, and sometimes as if it originated in the individual's conscious desires. The flight may be made from the world which tempts the person to gratify the instinctual impulse, or from the impulse itself. In short, all these defenses are for the purpose of protecting the ego from the danger it anticipates if it allows instinctual impulses to be expressed, and all the methods of psychotherapy are attempts to strengthen the ego, by removing the unreasonable fears, so that it can express and use these instinctual impulses.

The ideal case for psychotherapy would have the following characteristics:

1. The patient realizes that he is ill—i.e., that there is something wrong with him and that he cannot deal with the problem himself but needs the help of another person.
2. The patient realizes that he has feelings of fear and anxiety that do not seem to be reasonable.
3. The illness has not lasted too long.
4. The degree of secondary gain is not too great to be relinquished readily.
5. The extent of narcissistic behavior is not too marked.
6. The actual benefit to the patient from an increase in his psychic health will be actually greater than the benefits he obtains through his illness.

THE THERAPIST'S RESISTANCES

The defenses against the impulses were originally evolved as defenses against the use of the impulse in relation to other human beings. Now psychotherapy demands the presence of another human being—the therapist, which means that there will be manifestations of the original impulse directed toward him and that all the defenses against the impulse will also be defenses against the psychotherapeutic method and the therapist—all of which will interfere with the aim of therapy, which is the removal of the fear of the use of the dreaded but natural impulse in human relationships. The child who has sickened himself on candy and who comes to the psychotherapist to have his fear removed because his metabolism needs the gratification of sugars can say reasonably, "This man says that candy is wholesome, necessary, and not dangerous, but I know better because I have learned from experience that its use is associated with suffering. If this man says it is because I ate too much at one time, he may be mistaken. It may not be the amount I took, it may be the candy itself. He is only a man; furthermore his judgment cannot be good because it differs from that of my parents. Also, I feel I have gotten along perfectly well without candy, so how can he say that my body needs candy? Other people may, but I don't." If the therapist persists, he is ignoring the fact that the patient's present sense of reality is colored by his past experiences.

This brings to the fore another great difficulty in psychotherapy: the treatment involves not only the patient but the therapist as well. If the therapist himself believes that candy is harmful or has himself suffered an unpleasant experience with regard to it, how can he help the patient to get rid of the fear? If he has forgotten the unpleasant experience, in

order to keep the memory forgotten, he may be unable to see that the patient's trouble lies in his lack of candy or regard his fear of it as perfectly natural. Or he may understand intellectually that the patient's illness is due to his lack of candy but because of an inability to understand the dynamics of the boy's fear of ingesting it, he may immediately interpret the idea as such before the boy is ready to accept it. We know there are physicians who work wonders in curing maladjusted individuals because of an intuitive understanding of the patients and their emotional reactions, but such intuition is given only to a few individuals. On the contrary, how often one observes an intelligent, competent doctor acting in a way that indicates that he is totally oblivious of the patient's feelings. To ask, for instance, a shy, timid adolescent boy at the first or second interview to discuss masturbation indicates that the doctor has no conception of how he himself felt about masturbation during adolescence or childhood.

Psychotherapy cannot be learned from textbooks. If the therapist is more than usually intuitive, he can learn it by much clinical experience. But for most of us, a personal psychoanalysis is an absolute prerequisite, along with, of course, training in psychodynamics and in their application to the treatment of the individual patient. As a matter of fact, every physician needs a thorough knowledge of psychodynamics. Weiss,² with whom I agree, says, "We have been led to believe that the art of the physician, having to do with his common sense or intuition, as opposed to his science, is sufficient to grasp the problems that we have been considering. It is not enough. A real understanding of psychodynamics is necessary in order to study the emotional life in relation to ill health. It is my hope that every physician will be so trained that he may be able to understand and manage the many emotional problems that are presented to him daily. At the postgraduate level we need short orientation courses in centers that are properly staffed. At the graduate level better training facilities should be developed for residents in medicine, and the other medical specialties, to acquire the psychosomatic approach to medical problems. At the undergraduate level, we need, not more and more hours of psychiatry inserted into the curriculum, but a real integration of the psychosomatic point of view in every department, preclinical as well as clinical." Such a training in the understanding of psychodynamics, however, does not make the physician competent to manage the case of a child with a psychic illness, regardless of whether the

² Edward Weiss: "Psychotherapy in Everyday Practice," *Journal of the American Medical Association*, 137:442, May 29, 1948.

symptoms are expressed in the social, intellectual, or physical field. The understanding of psychodynamics and the ability to use such understanding in treatment—i.e., the ability to do psychotherapy of any kind—must be based on the personal psychoanalysis of the therapist. For instance: If one finds that the patient is not responding to psychotherapy, the first question should be, What is my own attitude to the problem? When one understands this, then the patient's problems and the nature of his defenses begin to appear more clearly and understandably. Furthermore, he must have an understanding of the child's total situation, a thorough acquaintance with the total reality of his life at various age levels. Finally, the minimum requirement for psychoanalytic work with children is a thorough acquaintanceship with children in a normal social setting.

THE GOALS OF PSYCHOTHERAPY

The methods of psychotherapy commonly used may be classified according to three goals, in descending order of desirability: those directed toward cure, i.e., an increase of the ability of the child's ego to accept or redirect his instinctual impulses; those directed toward increasing the child's ego defenses against his instinctual impulses—these defenses being needful because of the limitations imposed on the free expression of the child's instinctual impulses by the conditions of his age and by the circumstances of his environment; those directed toward increasing the child's ego defenses of a neurotic type, perhaps toward helping him to develop reaction formations.

THE METHODS OF PSYCHOTHERAPY

There are three types of psychotherapy for children:

- I. Education
- II. Abreaction
- III. Psychoanalysis

I. EDUCATIONAL PSYCHOTHERAPY

Before going into this type I want to point out certain procedures whose goal is to increase the child's neurotic ego defenses.

1. Moralistic therapy. Frequently a child who is very timid and restricts all his activities in order to avoid feelings of anxiety is told that he should not be so cowardly because the more cowardly he is, the less fun and greater discomfort he will experience. He is encouraged to over-

come his cowardice by attempting to be brave. If he follows this advice—of course doing so only to get the approval and love of the therapist—he will do so by attempting to repress into his unconscious not only the instinctual impulses which he fears and to which he is reacting by feelings of anxiety but also the feelings of anxiety which thereafter no longer serve him as a useful guide to his behavior. As a result, he may become overcourageous, sometimes to the detriment of his life and well-being. A woman on whom such therapy was inflicted as a child felt perfectly comfortable in going into the most dangerous parts of the slum areas of a large city in the small hours of the morning, even though her life had been threatened if she went there.

2. Showing the child the realities of his environment in order to help him give up his (apparent) fears about it. This method is used commonly in the treatment of children's fears, temper tantrums, etc. Often a child who has a phobia about dogs is encouraged to see that most dogs are not dangerous and that therefore there is no need to be afraid of them. Such therapy is based on the belief that the child is afraid of dogs and disregards the fact that what he is really afraid of is his own instinctual impulses, which he has projected onto dogs in order to relieve himself of his anxiety.

3. Diversion of attention. This form of therapy attempts to direct the child's interest away from his instinctual needs or anxieties to other activities. It is used commonly to prevent masturbation. Encouraging the child to take part in athletics or some other form of physical exercise in order to stop his masturbation is the commonest example.

4. The building up of assets to compensate for liabilities in order to solve a neurotic conflict. In the child who has a physical disability or whose basic intelligence or some special form of it, such as the ability to do abstract thinking in numbers or words, is very different from the average, it is necessary to survey carefully his assets and liabilities and to help him compensate for the latter by the opportunity to develop his assets—perhaps with considerable encouragement. But in the child who presents an inhibition of ego function and who does not have such basic defects, this method of therapy is only a diversion of attention.

All of these methods are based on the assumption that the cure for the child's emotional illness can be accomplished through the exaggeration of already present neurotic defense mechanisms or through the suggestion that he can profit by the adoption of such defense mechanisms. Their end result is to make the child less capable of utilizing his instinctual drives and therefore more liable to a severe breakdown on

meeting the stresses in life that are the lot of all human beings: the transition from high school to college or from school to work, falling in love, marriage, parenthood. Essentially they are methods of education, for education insists on the child's relinquishing the gratification of instinctual desires. I have discussed these methods in detail in order to indicate their undesirability.

The aim of real educational therapy is to help the child to be less afraid of his instinctual impulses and to learn to direct their expression in a culturally more acceptable way.

One method utilizes the relationship between the therapist and the patient and the hope on the child's part that if he pleases the doctor, he will in return gratify certain of his desires. Such methods are reassurance, suggestion, hypnotic suggestion, persuasion, conscious re-education. Their goal is to help the child to be more at peace with his instinctual drives, to learn that there are ways of gratifying them that do not get him into trouble with the adults in his environment, to sublimate some of them, and to develop a moderate degree of reaction formation against others. These methods fall into two groups:

A. Suggestion—whose sole purpose is the removal of the symptom, whether temporarily or permanently.

B. Re-education—whose purpose is to remove the guilt and fear concerning the instinctual impulses so that the child may be able to gratify them more adequately.

A. Suggestion: Suggestion may be employed in several forms:

(1) Unassisted verbal suggestion.

(2) Suggestion assisted by placebos or by the use of physical therapy—heat, light, electricity and hydrotherapy.

(3) Suggestion under hypnosis.

Psychoanalytic research has demonstrated that all suggestion is the result of one of two situations existing between therapist and patient. In the first instance, the therapist is kindly and persuasive and the patient regards him as the kindly, permitting mother who will allow him to say or do the things he fears without reproving him. In the second, the therapist is kindly but firm and the patient regards him as the firm but permissive father who commands him to do or say what he is afraid to and who will not punish him if he does. In both instances, the statement or act is one that has been forbidden by the patient's parents.

Suggestion produces certain intrapsychic changes. The oversevere superego, whose punishment the patient fears, becomes less threatening to the ego in the presence of an outside authoritative person whom

the patient trusts and who desires (commands or persuades) the patient to disregard the warnings of the punitive superego. The patient's ego identifies itself with the therapist and so does not fear the superego so much. The duration of this identification is uncertain. It may last only a short time, or it may last a year or so. Usually it is not permanent, and after a while the claims of the oversevere superego reassert themselves, perhaps along slightly different lines. The impermanence of the identification and the need for constant suggestion are well seen in those neurotic patients who visit their physician for the temporary relief of neurotic symptoms several times a year for many years.

Persuasion, which is a form of suggestion, is based on the same principles. The suggestion is reinforced by arguments that appeal to the patient's reason. For persuasion to be effective, the basic relationship used in suggestion must be established, and the permanence of the results depends on the permanence of the identification. Since persuasion, as well as suggestion, often involves encouraging the patient to undertake activities he has feared, the use of those activities may serve to drain off repressed impulses. This draining off may furnish sufficient continuous relief to the patient so that the intrapsychic conflicts may remain at a lower level of tension. The results of the use of both persuasion and suggestion are equally impermanent in adults.

B. Re-education: There are three types of re-education:

(1) The patient is given retraining as to the nature of human beings through intellectual insight into a better way of adjusting to life. This method is that formerly used by Dr. Riggs at Stockbridge. It depends on the utilization of the primary principles of education. In the education of the young child, he is asked to give up certain activities that bring him pleasure. He is reluctant to do so but feels that he will receive more parental love if he agrees, and in order to insure this increase of parental love, he makes the parental requirement—heretofore foreign to his personality—a part of himself. Similarly, the young child has many fears. The parents indicate that they do not dread the situations he does and that they will feel better pleased with him if he behaves more like them and gives up his infantile dreads. In order to receive the additional love, he makes the parents' statements that they do not have these fears part of his personality and regards any recurrence of the fears as childish and silly. These additional parts of the personality taken on by the young child from the admonitions of his parents remain fairly permanent in the adult's personality but are susceptible to later outside influences. During the process of re-education, the patient feels himself in

the child's position with a parent: if he admires and respects the therapist, he is willing to give up methods of finding gratification which the therapist indicates are undesirable and to accept other methods, as well as to give up childish terrors. The permanence of these changes in attitude and activity depends on the degree to which the patient can take over the therapist's point of view and on the real satisfactions he can get as a result of his changed point of view. Often, as in the case of suggestion, it lasts only as long as the actual influence of the therapist remains.

(2) An attempt is made to urge the patient to use existing facilities for the expression of repressed instinctual drives. This method is used at the Menninger Sanitarium.³ The therapeutic aims are to correct disturbances in the erotic and aggressive drives by the following devices:

A. In the erotic drives by

1. giving the patient love for which no return is expected
2. giving the patient an opportunity to love
3. giving the patient an opportunity to earn love

B. In the aggressive drives by

1. giving an opportunity for direct expression of hostilities
2. giving relief from a sense of guilt for inappropriate aggression
3. supplying opportunity for expression of sublimated aggression
4. encouraging displacements from previously disadvantageous love objects (i.e., from a disintegrating parent influence to a beneficial doctor-patient influence)

This type of education relies on the concept that instinctual drives must be expressed and that their expression can be made in ways that are compatible with life in society, beliefs that the patient has not thought possible because of his early childhood development. When he finds that such methods are possible and do not lead to external or internal punishment, he can continue to use them and so be relieved of tension. This method is successful only when used by a psychoanalytically trained physician. Change of environment is a special form of this type of educational therapy; so also is the use of properly managed nursery schools. Early and slight problems in children during the pre-oedipal stages where repression has not become marked may be helped a great deal, particularly in a nursery-school setting. The child with extreme reaction formations against disobedience and uncleanness, as the result of a marked attachment to a mother with similar reaction

³ Peggy Ralston: "Education Therapy in a Psychiatric Hospital," *Bulletin of the Menninger Clinic*, 4:41, 1940.

formations, can be educated to be less rigorous by association with teachers and children who do not have similar reaction formations. The child who is overaggressive because of inconsistent management can be educated through consistency—the mother, of course, requiring the therapy also—but this is successful only if used before three years of age. In four-year-olds it can be used as an introduction to psychoanalysis; if the child is in the phallic period, the ideal therapy is psychoanalysis. The parents of severely disturbed children are relieved when the child spends part of his day in nursery school and thus feel better toward the child, the improvement in the relationship to the child helping to give him a security he did not have before. In addition the child feels the security of the many hours he is in nursery school. Through weekly conferences the teachers know when the child is ready to profit by an environmental change; e.g., the fostering of contacts with other children when the patient seems to want them. At the same time the mother is treated, not by education or by analysis, but by psychotherapeutic methods. If the child's treatment in the nursery school progresses too slowly, he too may be treated by a psychiatrist.

(3) Reconditioning as a form of therapy was very popular a few years ago.

CASE 57. A man of thirty-three suddenly developed a fear that he would die. The fear was most pronounced when riding in an elevated train, particularly when the lights ahead were red. He believed that this would cause the train to stop and that he would be unable to get out. In using this form of therapy, the patient would be made to experience pleasant and satisfying sensations while riding in an elevated train. In this way, elevated trains would become associated with pleasure and not with pain.

This therapy does not deal with the inner conflict, which will only be displaced. I had a most unfortunate experience with this type of therapy when it was at the height of its popularity, as will be seen by the following case.

CASE 58. A pleasant, happy, contented little girl with normal physiological processes had a severe phobia of dogs. She was reconditioned successfully against this phobia and within two weeks not only no longer had the phobia but was overfriendly with every strange dog she met. On the other hand, she had become a whining, crying child, dreadfully anxious and unhappy, and ate and slept poorly. Her phobia had been removed, but the inner conflict began to show itself in all phases of her life. Reconditioning is not a valid method of therapy. Unless the fear

is faced by the ego, it remains. Unless the barrier between conscious and unconscious is dissolved, any amount of intellectual knowledge or transference-borrowed courage is fleeting. This applies chiefly to adults, adolescents, and older children. The various methods we have been discussing do afford some relief, but all are transference effects that leave the inner conflicts untouched.

II. ABREACTION

This type of psychotherapy is directed toward giving the child the opportunity to express his feelings of hostility, love, and fear and is accomplished by means of his relationship with the therapist. There are two methods:

- (1) Ventilation
- (2) Abreaction
 - (a) about the patient's life situation
 - (b) about the specific anxiety episodes
 - (c) in the transference

A. Ventilation: Ventilation is that form of therapy that offers the patient an opportunity to express his fears, ambitions, loves, and hates to a noncritical audience. In this situation he can verbalize, perhaps for the first time in his life, his real feelings and thoughts about people in his environment. For instance, a mother may hate her child and desire to be rid of him, but of course an open expression of such feelings would be unthinkable anywhere but in this therapeutic situation. Ventilation is accompanied by considerable emotional reactions—reactions that have had to be pent up lest the feelings become apparent to others. A mother who overprotects her child because she feels guilty about her hatred for him is satisfying both her guilty feelings and her hatred at the same time. Thus her handling of the child is to obtain unconscious gratification for herself without regard for the child's benefit. If in therapy she is able to ventilate her hostility toward the child without the fear engendered by her guilt feelings, she will be more conscious of her real feelings toward the child and can decide for herself whether she wants to express them or not.

B. Abreaction: Abreaction consists in the liberation of emotional reactions that had to be held in check during a very emotionally upsetting experience and have been repressed since.

(1) The first type of abreaction consists in the direct liberation of the repressed emotional reactions. There is a classical example of this. Freud reported the case of a man who had been very much attracted

to his sister. When she committed suicide, he showed no emotional reaction. Several years later, while casually visiting a cemetery in a distant city and idly gazing at old graves, he came to the grave of a poet of whom he had only heard incidentally and whose middle name on the stone resembled his sister's. As he looked at the grave, he was seized with an uncontrollable impulse to cry and burst into violent tears. He was abreacting the emotion which he had repressed at the time of his sister's death and was now displacing onto the poet. This type of abreaction is seen constantly in all forms of psychotherapy.

CASE 59. The mother of a child patient was either very submissive and concerned that I be happy or violently hostile without my giving her cause. These two attitudes were the abreacted expression of her feelings toward her father. Her conscious feeling toward him was one of indifference, and her conscious memories of her childhood seemed to indicate she was quite indifferent to his actions.

(2) Children's play provides an excellent example of the second type of abreaction. A child is taken to the dentist. He is very frightened in anticipation of pain. During the examination and treatment he is expected to be quiet and co-operative. Although his fear makes him feel like running away, attacking the dentist, or bursting into a panic, he has to suppress all these feelings. When he arrives home, he sits his younger brother in a chair, examines his mouth and teeth, and talks as the dentist talked to him. He is active where he had to be passive and can operate on and ill-treat the brother the way he was ill-treated. In this way he abreacts his suppressed emotions by changing his previous passive role into an active one.

During treatment the child dramatizes in play certain emotionally disturbing situations that are known to have occurred to him.

CASE 60. A boy was very kind and loving toward his obstreperous younger brother, of whom he was required to take charge, although he was not permitted to punish him. He had to take him to school and see that he got safely across a busy thoroughfare, but when on occasion the brother disregarded his own safety and his older brother's orders, the latter was not permitted to punish him. During treatment, he was asked to dramatize the situation and induced to punish his brother adequately. He was afraid to do so and succeeded only after much encouragement, whereupon he experienced a great release of feeling and much joy. Levy⁴ has pointed out that when a child suddenly de-

⁴David M. Levy: "Release Therapy," *American Journal of Orthopsychiatry*, 9:713, 1939.

velops anxiety attacks after a frightening experience, abreaction of the anxiety situation by having the child do to a doll what was done to him often cures the attacks.

CASE 61. A nine-year-old boy was tied to a telephone pole by some older boys who went away, leaving him there. The boy was very frightened but did not want his tormentors to know he was afraid. That night he had a nightmare that a man was taken to a cellar and tied to a post. The nightmare recurred until the boy became afraid to sleep alone. In addition he began to show anxiety in his daily life, being afraid of the dark, of going upstairs alone, etc. In therapy, he was given a doll, a post, and a piece of string, and was urged to tie the doll to the post as tightly as possible. In his first attempts, he did not seem to know how to tie a knot, and when he finally succeeded, the doll was tied so loosely that it fell away from the pole. With further urging his ability increased, and when he finally succeeded in tying the doll to the post properly—i.e., the way he had been tied—he was urged to repeat the performance over and over. Following this, there was diminution, then complete cessation of his waking fears, and his nightmares disappeared almost at once. This method is successful only in cases where the parental attitudes have not been adverse and where the child feels friendly and confident toward the physician and the physician intuitively understands how to make a child comfortable with him in a brief period of time. It deals only with the result of *real* frights and does not influence conflicts between instinctual desires and the forces of repression. If the physician is not certain what the situation is that is producing the anxiety, he can have the child thus dramatize certain common situations that may have been traumatic to him: a child sees a mother nursing a newborn baby; a child sees the parents making love; a child sees a naked child of the opposite sex. If the child is reluctant to dramatize his reactions to these situations, he is encouraged to persevere until he has abreacted them fully.

(3) As for abreaction in the transference situation: In analysis, abreaction plays an important role. The patient abreacts toward the analyst his childhood emotional reactions and does so because his unconscious has no knowledge of the passage of time. He is under the control of his unconscious. He does not realize that his feelings are not adequate to the present situation until it is pointed out to him. Of greater importance from the standpoint of abreaction is the fact that he is able to express his emotional reactions openly to the analyst, whereas he could not do so to his parents when a child.

Various methods of treatment that utilize abreaction extensively have appeared as modifications of the psychoanalytic technique. When Rank separated himself from psychoanalysis, he developed a method of therapy which he believed would shorten the time required by the procedure of psychoanalysis. He developed the theory that all neuroses were caused by the effects of the experiences undergone during birth. He believed that the patient should be forced to submit to definite and severe restrictions such as the limitation of his treatment to a period of a few months only. Under this regime, all of the patient's conscious and unconscious reactions would be interpreted as a reaction to the therapist and all memories of his childhood which were produced would be regarded *only* as resistances to expressing these feelings about the therapist. Allen⁵ has applied the same principle in his work with children. He sets limitations as to what the child may or may not do in the treatment hour and encourages the child by interpretations to express his real emotional reactions to these situations. He believes that as the child becomes able to express his real feelings in the treatment situation, he will be able to carry over this increased ability to react emotionally into his outside life. This type of therapy utilizes the principle of abreaction as applied to the relationship with the therapist and does not use abreaction as a method of getting rid of emotional reactions that were aroused and then controlled during a real traumatic event of the child's life.

In the use of both ventilation and abreaction, the child is seen by the physician once a week, and within certain limitations is allowed to do as he wishes. Interpretations of behavior are made in terms of the feelings the child displays toward the doctor in his activities. The child is encouraged to make his own decisions about what he wants to do. At the same time he must submit to the limitations imposed by the reality situation and by his decisions. In this way he becomes more aware of his own affects and more capable of handling them.

Both of these types of therapy are based on psychoanalytic principles and might be entitled "Educational Therapy through the Application of Psychoanalytic Knowledge." It is probable that the great majority of treatment techniques used by psychiatrists with children at the present time are based on psychoanalytic principles. Historically, the practice of therapy in psychiatry and all our knowledge of the psychic life emanate from the discoveries made by Freud and his pupils, even

⁵ Frederick H. Allen: *Psychotherapy with Children*, W. W. Norton & Co., New York, 1942.

though many practicing psychiatrists would deny the reality of this historical development.

III. PSYCHOANALYSIS

Psychoanalysis of children and adolescents differs from psychotherapy in that it focuses on the child's unconscious fantasies. This consists of three parts:⁶

1. The systematic investigation of (a) unconscious or as yet un verbalized pathogenic associations between certain facts, fantasies, and affects and (b) defense mechanisms developed or rigidified in the attempt to deal with these associations.

2. The systematic selective communication to the child of the results of such investigations.

3. A systematic follow-up that investigates secondary fantasies, affects, and defenses resulting from the treatment. The systematic check of the therapeutic situation must continue until there is evidence that the child's ego mastery has become more adequate for his age and can be expected not only to weather the next maturational crisis but also to exploit its potentialities.

The emphasis here is on the term "systematic." Other methods of psychotherapy, particularly if psychoanalytically oriented, uncover non-verbalized and unconscious pathogenic fantasies and the defense mechanisms that keep them unconscious, but they are not uncovered in the same systematic manner as in psychoanalysis. Psychoanalysis is the most effective and curative form of psychotherapy.

It is difficult to present the technique of psychoanalytic therapy to physicians and psychiatrists who have not themselves undergone psychoanalytic training, the basic principles of which I described in Chapter XV. In order to describe what occurs in the psychoanalytic treatment of a case, I shall present part of a case record.⁷

CASE 62. An eleven-year-old boy was referred because he had no friends, got along poorly with the other children at school, annoyed his teachers by continually arguing, asking questions, and talking, annoyed his parents—particularly his father—in the same way, was stubborn to the point of not submitting even after continued punishment,

⁶ For this formulation I am indebted to the discussion by the members of the Conference on the Indications and Criteria for the Psychoanalysis of Children and Adolescents, particularly to the chairman, Mr. Erik H. Erikson.

⁷ Read before the Baltimore Psychoanalytic Society under the title "Homosexual Problem of a Prepubertal Boy," January 31, 1948.

did not do as good schoolwork as he was capable of doing, and was poor at sports. The annoyance produced by his constant talk was well demonstrated in our first interview. From the very beginning he asked innumerable questions. He talked incessantly, and when I tried to talk to him he interrupted constantly with numerous relevant, irrelevant, and sometimes silly questions about the reason for and meaning of practically every word I said.

He was a sensitive boy, reacting to teasing—from which he suffered a great deal both from other boys and at the hands of his family—by showing his hurt feelings and withdrawing from the situation. He had marked mechanical ability. He had perfect hearing and considerable musical ability, and there had never been difficulty in getting him to practice. He was persistent. His curiosity was excessive, particularly along scientific lines (in which pursuit he had considerable ability). Although he had all these abilities, he used them like a child of six, which was about the level of his social development.

Examinations. Physically he was tall and ungainly, his poorly developed muscles tending to make him awkward. He was a real albino, and the absence of pigment was so great that he suffered excessively from any exposure to the sun, as well as from extremely defective vision.

His intelligence was above average by measurement. His behavior and his appearance caused his whole family, particularly his brother, who was four years older, to be ashamed of him.

History. He was the younger child in a two-child family. His mother had been married previously and had a boy and a girl by the first marriage, respectively thirteen and eleven years older than the patient.

His father was nearly fifty when the patient was born. He was a large, muscular man who set considerable store on physical prowess and felt ashamed of this puny child—a reaction to his own unconscious passivity, for he cooked and could do housework as well as or better than his wife. He was a marked obsessional character. He stated that he had felt it was wrong to rebel against any of his father's orders and that there was no sin as great as lying. When he was a boy his father had threatened him with punishment if he went to a certain place. He went. When questioned, he told his father the truth and was punished. He regarded his truth-telling as an extremely virtuous act. He stated that he would rather see his son insane than have him give up his belief in God and a hereafter of bliss or punishment. He was opinionated and prejudiced and was himself on the verge of an overt neurosis, perhaps a psychosis. He dominated the patient, blustering at him, punish-

ing him manually, and scolding him constantly in order to make him a more acceptable son. He too talked continuously, interviews with him consisting in my sitting silently and listening because it was impossible to get in a word.

The mother was a few years younger than the father and was quite socially minded, serving on the boards of various social agencies. She suffered from arthritis. She was rather helpless under her husband's prejudices and blustering. The patient had been conceived accidentally. The mother's health was good during the pregnancy, although she suffered a shock through the unexpected death of the father-in-law. The patient was a full-term child and was born without the use of instruments. The mother was unable to breast-feed him, but there was no feeding problem. Toilet training was easy except for some difficulty with bowel training, the training having been done not by the mother but by an Irish nurse who was really a substitute mother. She died rather suddenly when the patient was five years old; he showed no apparent reaction. Following her death, the parents engaged another nurse who was quite protective toward him. When he was six he became extremely stubborn, to the point where he tolerated even constant punishment. He did not talk until he was nearly four years old, and before that time he seemed to learn so slowly that his mother became worried lest he be retarded intellectually. When he was two and a half years old, she took him to an excellent psychologist, who told her that he was retarded one year. His mother accepted this judgment but continued to worry and tried hard and incessantly to educate him. Also, he was treated by eye exercises to improve his vision.

He started school at the age of six in a good private boy's school, but he was teased so much that his parents transferred him to a progressive school.

Treatment. I arranged to see him once a week; this is not ideal for analytic treatment, which requires four or five weekly visits. And in this regard I have found a real difficulty in the treatment of sick children in Philadelphia, a difficulty that even good child analysts in New York have found. Schools and parents combine to raise objections to four or five appointments a week unless they are after school hours, and to this the child objects because it interferes with his playtime. These adult objections are lessening, but it is only in exceptional cases that I am able to see a child five days a week—so far the best I can usually manage is three times a week. Infrequent interviews slow the child's progress in treatment, but on the other hand, if more frequent interviews

were insisted on there would be a higher incidence of early refusal of treatment by the child.

There are always two phases in child therapy, as Anna Freud pointed out years ago. The adult comes to a doctor because he feels sick. His symptoms make him uncomfortable. He has confidence that the doctor is a reasonable, decent human being who through superior knowledge will be able to help him. He makes a voluntary decision to be treated and has at least some will toward cure. The child, on the other hand, is afraid of all strange adults and particularly of physicians, who are associated in his mind with pain, suffering, and the mysteries of life and death. The child's feelings about the doctor are equivalent to the awe that the primitive feels for the medicine man. And particularly in the case of the rejective parent or of the child whose symptoms are non-conforming behavior, this dread and fear are often increased by the reasons the parent gives for bringing the child: frightening ones, saying the doctor will punish him if he doesn't behave, and so on. One boy was brought to me after being told that I would cut his head off to see if he had any brains!

In many cases, the child does not realize that he is suffering, for often his symptoms produce more suffering for his environment than for him. And even if his symptoms—e.g., chronic feelings of anxiety, etc.—caused him suffering, this suffering seems so much a part of his life that he cannot conceive of a life without it. He has little real realization of what the prospect of cure means. He has no insight that the malady is his, so he does not feel the inner necessity to place himself as unreservedly as possible in the hands of the physician. He has little or no will toward cure and makes no voluntary decision for treatment. Treatment interferes disagreeably with his plans, pursuits, and interests. Hence he has to be introduced into treatment through a period of time, during which rapport between him and the physician is developed. It is necessary for the therapist to induce the child to like him and to be interested in coming to see him. A preparatory series of interviews is called for, during which the child gets acquainted with the therapist and is induced to engage in conversation with him, learning by experience that he can be trusted and that he has the ability really to give him help in matters of his daily life. During this period and throughout treatment, the therapist has to be extremely careful to observe all the minutest conventions of everyday courtesy. For instance, even if adequate explanations are given, children resent bitterly being kept waiting for an appointment, having their time curtailed, having appoint-

ments broken and promises not fulfilled, and being ignored while the doctor talks with a parent. Any such behavior must be avoided by the therapist, if at all possible, if the child is to like him. Furthermore, the therapist must avoid judgmental attitudes or any expression of disapproval of the child's behavior. After the child has developed a liking for the therapist and a respect for his ability, psychotherapy can begin. In adhering strictly to such a plan, the therapist is dealing with the child as a respected, worth-while human being with feelings of his own—often a new experience for the patient.

Anyone who is planning to do psychotherapy with children is urged to read Anna Freud's ⁸ *Introduction to the Technic of Child Analysis* and Aichhorn's ⁹ *Wayward Youth*. Both of these books should be read not only from the standpoint of what is done therapeutically for the child but also for the methods of getting the child into a frame of mind where psychotherapeutic methods can be used.

Recently Anna Freud has found that this preliminary period can be shortened greatly by understanding and dealing with the child's resistances. As the first step in this process she attempts to ally herself with the child against his malady or against his parents (in the latter instance, she often has to help the child criticize people to whom he is attached) or she attempts to creep into his confidence by proving to him that she is more powerful than he is, that she can be useful to him by doing things for him, and by protecting him from punishment. She shows him that she has no intention of educating him.

As I do in all first interviews with children, I took the boy to the playroom, leaving the mother in the waiting room. When we were alone, I told him that I was a doctor who tried to help boys with their worries. I gave examples of other boys and their problems and told him that I had helped each case. I told him that his interviews with me would be confidential, that I was not going to report any part of them to his parents or to anyone else without his permission, and that he could tell me about anything in any way, using any language he pleased, without suffering any criticism from me. I told him that some boys liked to tell me verbally how they felt and that others preferred to show me how they felt by playing with the toys. I then showed him the toys and told him that he could do anything he liked with them and

⁸ Anna Freud: *Introduction to the Technic of Child Analysis*, Nervous and Mental Disease Publishing Co., New York and Washington, 1928. See also *The Psychoanalytic Treatment of Children*, Imago Publishing Co., London, 1946.

⁹ August Aichhorn: *Wayward Youth*, Viking Press, New York, 1935.

that I would not criticize him. I told him that he was old enough to realize that often adults were not truth-tellers or trustworthy and that I did not expect him to believe my promises at once but that if he tried them out, he would find they were true. I asked him if there were any questions he would like to ask me about myself or about the treatment. His desire to please me was expressed in his statement that he thought all my toys were nice, which was very far from their real condition. He mentioned that his defective vision made it difficult for him to take part in games. As I have mentioned, he occupied most of this interview with constant questioning. Toward the end, he told me that he realized some of his questions were silly and wanted to know what made him ask so many. I told him I thought he asked silly questions because he wished to ask many questions which he felt were shameful. He replied to this interpretation that he never thought of questions of that kind—a marked corroboration of the interpretation.

In this first interview, therefore, rapport was established. He desired help with two of his problems—his eyesight, about which I could not help him, and his incessant questions, whose elements of silliness he felt were alien to his ego. He did not recognize his fear of me.

A transference situation developed in the second interview. He told me that he asked so many questions and often silly ones because his father or mother usually were too busy to answer his questions even when they were important. He said that he wanted to play darts but asked me how such play would help him to get well. I told him that the best answer would be found by trying it and seeing what would happen. We played darts for a little while, then he changed to a marbles game in which he did not count the scores accurately. He asked me who played with the sand table, and before I could reply he asked me what had happened to the boy whose problem of stealing I had mentioned when I described in the first interview the kind of work I did. I asked him why he asked, and he replied that he was curious. Then he tried to fool me with card tricks, at which he was quite an expert. He had told me that his parents fooled him by not answering his questions and therefore he asked silly ones in retaliation, so he tried to find out whether I was like his parents. When I made noncommittal replies or did not answer his questions, he tried to fool me as he did them by pretending not to be able to count and by performing magical tricks. Thus he was able to transfer his attitude toward his parents onto me and to react to me as he reacted to them by retaliation through tricking. In later interviews, when I won a game he would accuse me

of trickery, a projection of his own inhibited hostility. In these early interviews, his eyesight problem recurred frequently, and he attempted to compensate for it in various magical plays—he had magical eyes and could hypnotize people, he liked memory and sight games, i.e., looking for a brief time at a number of objects and then enumerating them from memory, etc.

The next problem he produced concerned the transference situation. He could not decide whether to choose the red or the black checkers because he thought I might become angry or he might be unkind if he took the ones I wanted. He tried to make the decision by magical methods but denied that he had any fear of me. In this he was correct, his problem being not one of fear of me but of fear that he would be accused by me and by his superego if he were unkind; i.e., I and his superego would not love him if he were selfish.

During most of this preliminary period he played many games—checkers, marbles, and especially darts. These games have two functions. They lessen the child's fear of the adult and make him feel more comfortable and at ease, as well as allowing him a medium to express his instinctual desires and his conflicts about them. Every piece of play done by a child can be analyzed as a dream is analyzed, the structure of both being the same. In both there is an id and a superego content—in the dream because of sleep, in play because the child realizes consciously that he is only playing and therefore is not culpable. It is easy to recognize the unconscious elements in dramatic play and its close relationship to the dream in its mechanisms of distortion, displacement, condensation, and symbolization. The instinctual drives and unconscious conflicts are less readily recognizable in play which utilizes games, but they are present just the same. For example, several patients have recently demonstrated for me that an inability to play darts results from a fear of penetration with the penis and that a preoccupation with darts is a preoccupation with the same problem, although the actual fear of the idea is less.

During the introductory period, the patient gradually brought up his real problem—his fear of expressing or feeling friendliness toward other boys. He was shy to the point of immobility in expressing any friendliness, and when he felt friendly the feeling was accompanied by a thrill. It was this desire to be friendly with other boys and his fear of expressing it that resulted in the teasing he got which made him so sensitive. Actually because he so desired their positive feelings toward

him, he unconsciously caused them to tease him, the pain of the teasing punishing him for his desires. His sensitivity was increased also by the unmerciful teasing he received from all his family and especially from his older brother. Although during our discussion of this matter he gave many instances of teasings, he denied that they increased his sensitivity. After pathetically discussing his fear of being teased and inquiring whether through treatment it would stop within the following year, he brought the problem into the transference situation and began to annoy me in order to get me to retaliate. I pointed out that he behaved thus because of his wish to be punished by me; he agreed verbally but continued his behavior to the point where I had to stop him.

During this discussion he expressed a reality problem: since he could not see well enough to perceive facial expressions, he never knew whether people were in earnest or not, and when his parents teased him he tended always to believe what they said and became very upset as a result.

Now the preliminary period of treatment was over, for he began to produce the symptoms that bothered him. Why was he picked last to play soccer? Was it because he was nervous? Did he talk too much because he was nervous? He felt anxious and upset and therefore had to talk. Why was he nervous? I told him that his nervousness must be the result of his early experiences. He then told me a dream he had when he was less than five.

Dream: There was a white smokehouse and a repeated sound.

Two days after the dream he actually heard that sound and became very frightened. Also, he developed a phobia of white things, such as the cornstalk in his bedroom. He associated the dream with memories of his mother and of his beloved nurse who died when he was five, with enemas and suppositories which he disliked, and with thunder. From this point on, he refused to go to the playroom, preferring my office, where he either sat on the chair or lay on the floor or on the couch and talked. During his first office interview, he returned to the dream, saying that he thought his fear in the dream was a fear of being scolded. Then he told me of his father's fussiness and how frequently he yelled at him. (This had been corroborated by the mother, who said that the only time the father treated the boy at all well was when he raised an abstract subject for discussion.) Then his argumentativeness and questioning increased. It was easy to see that he

was attempting to prove me wrong, to express disbelief and uncertainty, and, less often, to get me angry. At the same time he told me of the pleasure he got from practical jokes.

After this transference manifestation of his anal sado-masochistic feelings toward me, he produced his first real phallic dream:

Dream: Mr. A. beckoned to a pretty girl, and the patient was envious. He was afraid he might roll down a hill and fall into a dangerous well, but avoided the catastrophe.

The homosexual problem. His associations and his feeling at the next interview to the effect that he would have liked to knock on my door because I was busy with another patient showed that this was a homosexual dream and expressed his desire for my attention as well as his father's. He corroborated this interpretation by expressing his displeasure in the abrupt ending of his interviews, his wish that I would hypnotize him, and his envy of his mother because she could sleep in the morning while he could not.

About the same time he referred to a problem that bothered his parents greatly, i.e., his difficulty in getting to bed on time and his inability to fall asleep once there. The second difficulty, of course, was consecutive to the first: he did not want to go to bed because he could not fall asleep; he could not fall asleep because of his masturbation problem, which was that he was compelled to touch his penis but feared to do so because his brother had rebuked him for it and because his mother had told him that urine was poisonous.

This dream also brought out another phobia. He had a great fear of being locked in a room. This was really a phobia of being buried alive and acquired its content from a story about a man who was buried alive, told him by his brother to frighten him. In this connection, he told me that his nurse had discussed death with him about a year before she died. He believed his brother's attitude toward him had changed after her death.

With this material he was able to talk more about his homosexuality. He was intensely interested in soldiers, but instead of wanting to discuss this interest with me, he wanted me to tell him how to start a conversation with them. His homosexual trends again appeared in a dream.

Dream: He wandered off the road through a forest onto a trail to the left, going through heavy foliage. It got dark, and he was afraid he would get lost.

His associations were to his anger because of the protective attitude

of his friends toward him. They recognized his visual defect and on the day of the dream had prevented him from stepping off the edge of a high platform. He became so angry at their help that he started to do things they disliked, doing so because he felt the boys were bad and because he was afraid he might lose control of himself. When the homosexual significance of left and his fear of it were interpreted, he acquiesced.

Two interviews later, he suddenly became paranoid. He entered in great fear, stating that he was afraid of a man in the waiting room. The man had asked his name and where he lived, and he immediately suspected that the man was going to follow him home and break into the house. This material brought up a difficulty he had in school. A boy about his age teased him a great deal and was in the habit of poking him in the genitals with intent to hurt him. This usually occurred in the locker room either before or after the gym period. (Such occurrences are extremely common in school, especially in the locker or shower room. They so frighten a timid boy that often he expresses his difficulty by refusing to take gym classes.) I took action in this matter, as I have done in other similar cases, by insisting that the physical-education teacher exercise more supervision during these periods.

By this time it was evident that the patient had a pronounced latent homosexuality of which he was extremely frightened because it implied castration. In order to avoid the homosexuality and the castration fear with which it was associated, he tried to project the whole problem and as a result showed a tendency to develop a paranoid psychosis.

The question now was what was the genesis of the homosexuality. Shortly after this episode he had another dream:

Dream: He was on his own street. He saw a goat caught in an iron fence. He moved over and started to take it out but it charged him. He grabbed it up by a rope, whirled it in the air, and let it down. It slid on its belly and he said "bellyache." Then it was not a goat but a girl with red hair.

He went up a hall and heard men singing like Sinatra. They sang, "That girl hurts him in his head."

The girl was a former schoolmate whom he had teased a great deal, she pretending to be hurt. He discussed the fact that his interest in soldiers was exactly the same as his interest in girls. He could openly express his interest in soldiers because no harm would come to him,

whereas, if his interest in girls were detected, he would get into trouble.

This expression of one determinant in his homosexuality—i.e., it was less dangerous to be homosexual than to be heterosexual because in the former case men, his rivals, would not be angry—was followed by a dream.

Dream: He was coming to his appointment but could not get there. He decided to try over again but had the same trouble. He was in a bad fix and did not get to the appointment because the car turned off to the right.

His associations were to the interest soldiers seemed to show in girls. He had gone to a party the day before where there were girls of his own age. His brother had not wanted to go, perhaps because in the past the patient had humiliated him by making himself conspicuous. He had made some awkward adolescent advances to the girls but could find nothing wonderful about them. He did not like to admit that girls were worthy objects. Then he discussed his fear of being "goosed," which was happening constantly at school. He was jealous of boys who were interested in girls.

The patient's sexual ideas. This was followed by dreams about being buried alive, to which his associations were of pregnancy and intra-uterine life. Then came an important interview. He had asked his father about intercourse, which the father had explained with great inhibition. In discussing the problem with me, he said that while masturbating he fantasied that he was having intercourse with a girl and sometimes made a figure of a girl to masturbate on. He had the idea that he might urinate in the girl and that it would be disgusting. I corrected this idea. He thought intercourse was only for procreation. I corrected this idea. He stated that he admired soldiers and wished to be treated as a girl by them because he was afraid that he would injure the girl in intercourse and he would rather be injured himself. He admired soldiers because his eyes made him inferior but if he had a uniform he would not feel so much that way. Perhaps he could become a Boy Scout and so have a uniform. During the next week he joined the Boy Scouts, in which he got along well.

Shortly after this he had a fantasy that he was Superman and was rescuing soldiers. He had so much respect—i.e., awe—for servicemen because that was the way he felt toward his father. I told him he had too much awe of his father and too little respect for himself.

In the next interview, his admiration for servicemen had changed

to admiration for servicewomen. His admiration for a particular Wave, in fact, was greater than any he had felt for soldiers. He feared this feeling, however, because his eye difficulty made him inferior. He had had great difficulty in recognizing a girl whom he had met previously, and felt embarrassed by this. He felt, also, that his father was more interested in him than his mother was. This, unfortunately, seemed to be true.

At this point, he was really trying to perceive that his interest in girls was greater than his interest in soldiers. This caused him to produce his concept of heaven. A part of him would be inside heaven and a part outside. The two could meet and then he would see God, who was an old man with a beard. This idea was based partly on the idea of purgatory which I think he had learned from his Catholic maid. Purgatory was also associated with his fear of being buried alive, which would be a punishment for his sins. The worst sin he knew was lying. At this point I tried hard to reduce his conscious distorted concept of sin, whereupon he produced deeper material. He admired soldiers because he wanted to shake their hands; if he did so, their strength would flow into him—a confession he had feared for months to tell me. This was another basis for his homosexual orientation. He felt weak and ineffectual because of his fears about sexuality and because of his physical defects. If he could get a man to love him physically, he could extract power from him, and in the process the man would lose his power. The extraction-of-power idea had been conscious but concealed from me; the idea of castrating the soldier in the process of gaining power had been unconscious.

His admiration for men and its effect on him differed even in its physical manifestations from his feelings toward women. When he thought of the latter, he got a thrill over his entire body and a semi-erection. He also tended to get an erection if he looked at, touched, or thought of a person's feet, regardless of the sex of the person. The fact that he got an erection indicated that he had more strength than he thought. He told me he disliked women's breasts, legs, and thighs. However, he had a girl friend and thought of marrying her. At this point, he referred to the dream of the road to the left and thought that the beaten pathway off which he had wandered was his desire for his penis to be touched as his nurse had done often when she bathed him (his mother occasionally bathed him still). His reason for wanting to wander away from such a desire was that his brother picked on him when he showed his devotion to the nurse.

This information was followed by a discussion of risqué stories, which were banned in his family. Again I tried to reduce his distorted ideas about such stories. Very soon after this he produced a flood of corroborative material. He pretended to admire soldiers and men because he felt inferior to them and so was afraid of them lest they learn that he really liked girls—liked to be with them and to look at them (formerly also to be touched by them). He was very fond of his mother but felt he could not dare to show this fondness. It would be safe to be fond of her only if he were inside her, which was the same to him as being buried alive. His constant questioning of the father at dinner was done to keep him from talking to the mother. He had spent much energy in trying to keep the parents separated and would become violently angry inside if anyone tried to keep him from monopolizing the mother. He was extremely afraid of his terribly strict father and had used certain magical methods to avoid his feeling of fear. His fear of being buried alive was an expression of his guilt for wanting to keep the father away from the mother and have her for himself. He began to ask me for help in handling the reality situation with his father, but through discussion came to realize that it was hopeless to expect much change in his father's attitude and resigned himself to the situation.

Shortly after this, at his request, treatment was reduced gradually to once a month. After he had been on this widely spaced schedule for some time, he had his first wet dream.

Dream: He was in the bathroom and his maid curled her toes about his extended finger. Then he had an emission.

This dream was a heterosexual one. I do not think this dream was so pathological for the first wet dream of an adolescent. It showed that his masturbation problem, his fear of the female genitals, and his foot fetish had not yet been worked out.

The results of treatment. By this time he was attending dancing school and enjoying it, going to and enjoying parties, and having a good time with girls. He was an active, interested member of the Scouts and was not being teased by his schoolmates. In fact, he was rather a respected person because of his musical ability and his willingness to play for them whenever they wanted him to. He was now able to listen to risqué stories and use vernacular words. He was using his music, also, as a means of entertaining older people. At his summer home he played for many of the neighborhood dances. His schoolwork was good, and there were few complaints about his conduct. He enjoyed playing soc-

cer and doing remunerative work. His mother and he got along fairly well. He recognized that his father had many unrealistic points of view, but decided that since he could not change them, he would simply listen to him without the need to argue or to express a contrary viewpoint. If his father insisted that he state his point of view, he would state one with which his father would agree, knowing that he was lying but not being bothered by it. He hoped some day when he was older his father would consider him no longer a child but would show him respect. He was willing to wait for that time to come.

He had wanted to compensate for his physical defects by learning to drive a car and to fly and actually began to earn money for flying lessons. However, he himself came to the conclusion that he had better not fly, and although he had had driving lessons, he was not anxious to try his driver's test yet—an entirely different attitude from the one he showed at the beginning of his treatment. He was sublimating his curiosity along scientific lines, at first by reading up as much as he could find on sexual facts and later by an interest in chemistry. It seemed probable he would be a chemical engineer.

Psychopathology. This patient's presenting symptoms—his inability to make and retain friends, his being teased, his incapacity in sports, and his continual questioning and arguing (which symptom was the main reason for his referral)—would at one time, and perhaps not infrequently now, have been looked upon as attempts to attract attention, the interpretation of their dynamics being that they were a compensatory reaction to his feelings of inferiority, feelings resulting from his physical defects—severe and unimprovable visual difficulty, lack of ability to withstand sunlight because of albinism, albinic appearance, and inadequately developed musculature. (I myself was most impressed by his inability to observe facial expressions. It would seem that tone, inflection, etc., of the voice do not convey even to a person with perfect hearing the speaker's emotional attitudes and that we depend more on facial expression than we do on hearing to ascertain how others feel toward us. Such a diagnosis would fall into the Adlerian error of rejecting Freud's concept that the Oedipus situation is the nuclear complex of the neurosis, as well as the important role that sexuality plays in the etiology of the neurosis.

The case material indicates that the patient's actions were true symptoms, but the instinctual drives and the reasons for the repressive forces—which go to make up the dynamics of any symptom—were not apparent until the homosexual problem was unearthed. The teasing by

the other boys was precipitated unconsciously by the patient as a passive attempt to seduce his companions to attack him. His talking and arguing with his father and other men had the same instinctual wish. The repressive element appeared in the pain such behavior caused him. His inability to make and retain friends and his inadequate performance in sports represented his attempt to avoid the fear of the homosexual components in these activities. (It is interesting that he was able toward the end of treatment to enjoy playing soccer despite his physical handicaps and that in the course of the uncovering of his homosexuality he was able to join the Boy Scouts, to make friends there, and to participate efficiently and pleasurably in their pursuits.) The case material—particularly the analysis of the dream of the beaten path and the road to the left—illustrates clearly the unconscious homosexual basis for friendship: the boys had tried hard to be kind to him and he had become irritated because of fear of his homosexual feelings. He was so afraid of his homosexuality that he became angry when it was uncovered and had a mild transitory paranoid attack, in which he used the mechanism of projection. This mechanism of projection—i.e., the fear that the man would injure him—was based originally on reality—i.e., there had been an irascible man (his father) who was really likely to hurt him (by punishment). The patient's main symptoms were an expression of his unconscious homosexual drives of a passive anal nature—a desire to be teased, beaten, and used. The repression of the homosexuality was due to the same reason that the homosexuality developed—the fear and guilt (particularly the fear) of the underlying hostility and jealousy. I believe it to be due more to fear than to guilt because his father was in reality such a threatening, dangerous person that any expression of instinct—either sexual or aggressive—would be punished immediately. Since the patient was a child, his superego—although it was quite apparent and very threatening—was not completely crystallized, and the real father was at least as important as the threatening father image in the superego.

The boy's homosexuality was his way of avoiding his hostility and jealousy toward the father because he feared the latter's retaliation. He fled into homosexuality because of his wishes to castrate—take power from—the father and take his wife away from him. He feared to be conscious of these wishes and so replaced them by an attempt to identify himself with the mother and occupy her sexual position. His identification with the mother was an attempt to avoid a deeper wish: to return to the mother's womb; i.e., the phobia of being buried alive. Before

discussing this phobia, let us note that the identification with the mother and the consequent homosexuality were secondary reactions to avoid the phobia itself. The fact that this underlying phobia was present indicates that the boy suffered from anxiety hysteria, which means he had reached the phallic stage of development. In my opinion, the majority of character neuroses in children and adolescents—and his was a character neurosis—are secondary elaborations of either conversion hysteria or anxiety hysteria. As I have mentioned before, even some of the complicated adolescent educational difficulties are an attempt at further defense against a deep-seated and long-continuing phobia.

The phobia itself—i.e., the dread of being buried alive—was a fantasy of a return to the mother's womb, but the pleasure of the fantasy had been turned into pain and the idea of the womb had been replaced by the idea of a coffin and the engulfing earth. The original wish concerned the mother, as was apparent from the content of the dream of a white smokehouse he had had before he was five. Here there is little distortion of the fantasy of returning to the uterus. A further distortion of the fantasy occurred after the sudden death of his nurse and his longing for her was condensed with his longing for the mother. The smokehouse became the engulfing coffin and earth through which—still alive—he would be reunited with both mother and nurse.

He had to repress his longing for the mother and the nurse because of the fears produced by it. The longing itself was increased by the fact that the mother rejected him for several reasons. He was an accident, for she had mild arthritis, was interested in community affairs, and did not want to have another child. He was physically unattractive and unhealthy as a baby and was extremely slow in intellectual progress. When she was told he was backward, she reacted to her fear and guilt by striving hard to make him improve, and in doing so set higher standards for him than he could live up to. Her attitude of simultaneous rejection and attention was balanced by the presence of the nurse, who gave him considerable love, although his older brother was her favorite. Her death when the patient was five was a very traumatic event, as is made evident by the fact that he showed no reaction to it at all. His relationships with the women in the household were uncertain. He longed for their love and the longing was increased by their attitude toward him, but he felt this longing to be dangerous since it brought such unsatisfactory results. The object love was repressed not only because of the women's attitudes but also because of the jealousy situation it entailed with his brother, who was cruel to him, and because of fear

of his hostility to the father, who was domineering and castrating to the boy. His object love was repressed, and the repression forced him to regress from object love to identification with the woman.

There is an interesting point about this identification with the mother. Its purpose is to be the mother and therefore possess her, but it took the form of a desire to possess her by being inside her—the intra-uterine fantasy. The purpose of this fantasy is well illustrated by his conscious ideas about heaven. There was a part of him on earth—i.e., himself—and a part of him in heaven—i.e., his nurse. A time would come when they would join together to become one. He would identify with the nurse and then he would see God—i.e., be his father's wife. The basic purpose in this was to castrate the father by taking his power from him during intercourse. The identification with the mother was not a complete identification. It was an impersonation and was basically an object relationship. He would be in his mother's womb and get phallic gratification with her and at the same time would be penetrated by the father during intercourse with the mother. When he was penetrated by the father he could remove the father's penis in safety. This impersonation is similar to one in the Restoration poem about Nell Gwynne which states that she induced her father's penis to penetrate her vagina while she was in her mother's womb.

I would like to discuss briefly the dynamics of certain of his major symptoms. His argumentativeness was an expression of his desire to ask constant questions which, though often silly, irrelevant, and inconsequential, were also often pertinent. This pattern was due partly to the fact that he could not see clearly and therefore had to ask to have his defective visual impressions defined more clearly for him. It served also as a method of relieving him of anxiety and fear. If he could ask directly or indirectly—by engaging the person in conversation—how that person felt toward him, he would compensate for his inability to see the facial expression. It served, too, to help satisfy his intense curiosity, particularly about matters of sexuality and death, and because he was refused answers on both of these topics because of his parents' prudishness, he tended to ask more and more less relevant questions. Part of the reason for the irrelevancy was his fear to ask the question directly, but part was because of a spiteful attitude at their refusal to answer: if they would not answer his real question, he would retaliate by asking them questions they could not answer. It served as a defense against his longing to be loved, particularly by the father. Instead of listening to what the father said to him, he would pick up an unimportant phrase and ask innumerable questions about it. In this way,

he would remain immune to the spirit of the whole idea his father was expressing. Since this aroused his father's anger, the pattern served as an unconscious attempt to seduce the father to attack him and so was an attempt to gratify his unconscious homosexuality. At the same time he could gratify his castrating wishes toward the father, as the homosexuality itself was an attempt to deprive the father of power.

His extreme sensitivity, particularly to teasing, was based on the conflict between his pride, hurt because the teasing put him in an inferior position, and his passive submissive masochistic desires to be attacked and mastered.

The technical measures employed with this boy were the usual ones—development of rapport by aligning myself with the boy against his parents and his difficulties, interpretation of his unconscious desires, and the use of the transference and interpretation of it. I treated this patient directly and made little attempt to alter the attitudes of his parents, since it was impossible to get any co-operation from them. Even toward the end of treatment, the mother wanted the boy sent to a boarding school so she would be freer. The father was adamant in his dogmatic prudish views on ethics. Therefore, I decided not to allow the transference element to be entirely dissolved. After he felt he could get along on treatment less than once a week, I acceded to his desire to return about once a month, and I intend to see him at intervals throughout his adolescence. I made this decision because I felt that his ego was still too weak to cope with the difficult family situation and that I would help him strengthen it over a long period of time. I have done this with a successful outcome in other cases when there was no possibility of changing the parental attitude.

I do not feel that the favorable outcome in this case was due entirely to my efforts but resulted also from the fact that the boy's instinctual drives were not very strong and that therefore his conflicts would be less disturbing. Constitutionally he was poorly put together, and I felt that his instinct life was also weak. He had much weaker sexual impulses than most boys, as is evidenced by the sparsity of wet dreams. Therefore, he did not require as strong an ego as most males do. In treatment, this meant that he was not so frightened by the emergence of his sexual feelings as many prepubertal children are.

The case illustrates the systematic uncovering of the child's pathogenic unconscious fantasies and the systematic uncovering of his defense mechanisms. The boy felt that he had problems, and therefore the co-operation of his parents in undertaking some therapy for themselves was not as necessary as it is in many cases.

THE RECENT CHANGES IN THE TYPES OF
CHILDHOOD NEUROSES

Sterba¹⁰ believes that childhood neuroses have changed in recent years. She never sees a clear circumscribed phobia or a fully developed compulsion neurosis, and rarely sees phobic or obsessional mechanisms and night terrors. Sometimes she does see sleeping disturbances, fears of being left alone, and eating disturbances in early childhood, though obesity caused by neurotic voraciousness in the latency period is much more frequent and more serious than disturbances that consist in not eating. Nocturnal and diurnal enuresis and soiling are very frequent, most of these children not being completely toilet trained at any age. Most of her cases present more or less serious temper tantrums, neurotic aggression or destructiveness, symptoms of delinquency such as stealing or truanting, intense sibling rivalry, resistance to all authority, immature behavior at school, learning difficulties, etc. Thus childhood neuroses seems to have changed within recent years from anxiety neuroses and compulsion neuroses to behavior problems such as extreme aggressiveness, bedwetting, soiling, voraciousness, all of which are characterized by the complete lack of the development of normal instinctual control. This lack of control, she believes, results from the fact that psychoanalytic principles are wrongly applied in education. Which might explain why successful psychoanalysis of the child is possible only when parents are ready to accept educational or even therapeutic work for themselves.

THE TYPE OF ILLNESS DETERMINES THE CHOICE
OF THERAPEUTIC METHOD

The therapeutic method employed in a particular case depends on the type of illness from which the child suffers. The classification of the psychic disorders of childhood that I have presented in this book is helpful in determining the type of therapy. Psychic illness in children can be classified broadly into three groups:

1. Environmental—in which the therapy is directed solely toward the environment.

2. The transference neuroses—anxiety states, anxiety hysteria, con-

¹⁰ Edith Sterba, report by letter to the Conference on the Indications and Criteria for the Psychoanalysis of Children and Adolescents, Washington, May 15, 1948.

version hysteria, compulsion neuroses, perversions, and character neuroses.

3. The narcissistic neuroses—the psychoses.

Children suffering from a transference neurosis have experienced an injury in their relationship with other human beings and have withdrawn their capacity to remake relationships with others and turned it onto memories of persons with whom they formerly had such a relationship, usually the parents. As a result, they deal with their instinctual impulses as they had to while they were younger. They are still quite capable of making and maintaining relationships with others. The different types deal with the fears of their own desires in different ways. In conversion hysteria, the main defense mechanism is repression. The relationship with others remains firm, although part of the libido is directed toward fantasied objects. In the cases of pregenital conversion hysterics, the actual relationship with other things and people has been partially loosened, so that these states form a transition between the transference neuroses, where real relationships still exist, and the schizophrenic reactions, where the relationship to objects has been given up. In anxiety hysteria the main defense is repression and projection onto a phobic object. Adults who suffer from this condition are suffering from a second attack, having had a similar illness in childhood. In my experience, the nature of the childhood attack has a prognostic significance: if it was a phobia of an object that really exists and that is fear-inspiring, the adult attack is more amenable to treatment; if, on the other hand, the phobic object was unreal—a dinosaur-like horse that looked in the window at the child, the picture of a wolf dressed as a man, the growth of the beanstalk in the movie of Jack and the Beanstalk—the secondary attack in adult life is difficult to treat. Here the original phobic object was a figment of the child's imagination and had the nature of a delusionary idea. His environment was extremely adverse to his development, and withdrawal from reality into daydreaming had already become a valuable mechanism for meeting difficulties. In these cases I believe that we are dealing with a schizophrenic reaction on which the phobic reaction has been superimposed. The future course of these patients' development will probably be in the direction of a marked schizoid tendency—i.e., an attempt to deal with difficult situations by denying the reality of their existence. Thus even as children, these patients had already lost contact with reality.

In obsessional neurosis the ego attempts to relieve the repression by

regression to the anal-sadistic stage of development. In regression there is a return of the repressed, and secondary defense mechanisms are developed to keep the repressed unconscious. In the perversions both repression and regression have occurred but the ego, because of libidinal fixations, does not defend itself against the impulses liberated by the regression. There is no loosening of the ability to make relationships with others, but the pervert has to make them on a pregenital level because of his fear and guilt about genitality. In Case 42 (Chapter XI) the boy turned to homosexuality because he was frightened and guilty about his sexual feeling toward women, avoiding them as well as any masturbation fantasies about them. He continued to need sexual gratification, but now he had to obtain it through sexual relations and masturbation fantasies about males. As long as he was able to avoid or not care about the censure and disapproval of society for his form of sexual gratification, he did not feel that he had any problem and thus treatment would be of no value to him. As a matter of fact the main treatment difficulty with cases of perversions lies in the fact that the secondary gain from the behavior—in this case, the sexual relief from homosexual relations—is so effectual that the person experiences no suffering. Thus treatment can start only after the patient has been really convinced that by relinquishing homosexuality he will become a socially happier, more contented, and more successful person. In the character neurosis the repression is maintained by alterations in the character which are partly reaction formations and partly sublimations. I have discussed the treatment and modifications necessary in some cases of character neurosis in Chapter XIV.

The type of therapy most desirable in the transference neurosis, whether of child or adult, is psychoanalysis. It is most effective in anxiety states, in conversion hysteria, and in anxiety hysteria uncomplicated by other conditions. If this is impossible, the modifications—ventilation and abreaction—are the next most helpful types. Suggestion, persuasion, and re-education are of help only in removing the symptom.

In the narcissistic neurosis (the psychogenic psychosis) the situation is vastly different from that in the transference neurosis. Here the patient has been forced to give up his relationships with other people. A very schizoid man—not completely schizophrenic—told me that he had had a dream in his early adolescence that all the world except himself had been destroyed and that since that time he had gradually withdrawn from people, although not completely. He was able to ignore his surroundings completely: his wife had an argument with a man in his

presence, and two minutes later he had no idea what had been said. Another man, whenever he met a slight difficulty with other people, invariably had a dream that he was sucking his own penis; i.e., he had no need for any relationship, sexual or otherwise, with any person but himself. The relinquishment of relations with others is a withdrawal of interest and can become very great. Freud quotes Schreber as saying, "Men appear only like cursory contraptions." As a result the patient's libido is inturned. His repression breaks down completely because it is not needed to enable him to adjust to other human beings. The separation between the conscious and the unconscious disappears, and often the patient is able to report ideas and feelings that remain unconscious in other people and that can be brought to consciousness only with great difficulty. The delusions and hallucinations seen in psychotic persons are really slightly distorted unconscious ideas and feelings that we all have. The distinction between normal, neurotic, psychotic, and delinquent is a simple one. For instance: A man whose business is not going very well and whose father is wealthy but stingy has the natural thought that if his father died he would be better off. If he is normal, he may have that thought *consciously*. Then he has to decide whether it would be more advantageous to him to kill his father, take his money, and expose himself to the danger of execution, or to bring pressure on his father to give him some money, or to work harder at his business and make more for himself. If he is neurotic, he may not have the thought *consciously* but may instead develop fears about his father's health, at the same time finding that he is accidentally leaving objects around over which his father might slip or perhaps wanting to kiss his father when he has a bad cold. If he is delinquent, he may kill his father. If he is psychotic, he will tell you that his father is dead and that the man to whom he has just been talking is not his father.

The therapeutic problem in the treatment of psychotic children is different from that in the treatment of the neurotic—there is no question of attempting to make the unconscious conscious. The therapeutic problem lies in the interference in the patient's relationship to other human beings, an interference caused by terrific fears. The psychotic child or adult feels internally that he is useless, incapable, weak, and that no human being can have respect for him. He feels as the infant does in a world of powerful adults and frightening experiences. It is this inner feeling of worthlessness and hopelessness that causes his flight from relationships and that makes therapy so difficult. The schizophrenic's thought processes do not follow the laws of ordinary

conscious logical thinking but are governed by the thought techniques of the unconscious such as are found in dreams. Consequently, it is difficult for the nonpsychotic person to understand him. Furthermore, the schizophrenic gives to the words used both by himself and by other people meanings different from those usually accepted. For these reasons it is very difficult for patient and therapist to establish a common basis of understanding.

The main difficulty in therapy is the barrier of withdrawal from relationships by which the patient protects his shrinking sensitiveness and because of it suggestion, persuasion, ventilation, and abreaction are useless, for their efficacy depends entirely on the patient's ability to form a strong personal relationship to the therapist. The one therapy that offers any possibility of improvement for the schizophrenic child is psychoanalysis, though the technical procedures often have to be considerably modified.

Other child psychiatrists have different concepts of the dynamics of children's emotional illnesses, and their technical therapeutic procedures are therefore different from what I have been describing. The most important of these is that of Mrs. Klein.¹¹ She is convinced of the validity of the psychoanalytic concepts, but in her treatment techniques little attention is paid to the child's resistances and defenses; instead she interprets to him as quickly as possible his deep unconscious ideas and feelings. Such a procedure demands from the therapist an extraordinary ability to understand intuitively the unconscious of the child. I myself do not understand how she eliminates the child's defenses and resistances.

The interested reader will find a discussion of still other techniques in Witmer,¹² Harms,¹³ Rogers,¹⁴ Lewis and Pacella,¹⁵ Hamilton,¹⁶ and Allen.¹⁷

¹¹ Melanie Klein: *The Psychoanalysis of Children*, W. W. Norton & Co., New York, 1932.

¹² Helen Witmer: *Psychiatric Interviews with Children*, Commonwealth Fund, New York, 1946.

¹³ Ernest Harms: *Handbook of Child Guidance*, Child Care Publications, New York, 1947.

¹⁴ Carl Rogers: *The Clinical Treatment of the Problem Child*, George Allen & Unwin, London, 1939.

¹⁵ Nolan D. C. Lewis and Bernard L. Pacella: *Modern Trends in Child Psychiatry*, International Universities Press, New York, 1945.

¹⁶ Gordon Hamilton: *Psychotherapy in Child Guidance*, Columbia University Press, New York, 1947.

¹⁷ Frederick H. Allen: *Psychotherapy with Children*, W. W. Norton & Co., New York, 1942.

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